Consent for Medical Treatment of a Minor Child

This is a legal document. Give it to a physician, dentist or hospital representative when medical, dental, surgical care or hospitalization is required and the child's parents cannot be reached for permission.

I (We) _____ and _____
(name) *(name)*

do hereby state that I am (we are) the parent(s) or legal guardian(s) of:

_____ , a minor, age _____ , born _____/_____/_____
(name) *(date of birth)*

who resides with me (us) at _____
(address)

in _____ , _____ , _____
(city) *(county)* *(state)*

I (We) authorize _____ , an adult, who resides at
(name)

_____ in _____ , _____ , _____
(address) *(city)* *(county)* *(state)*

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s)

during the period(s) of my/our absence from: _____ / _____ / _____ through _____ / _____ / _____
(month, day, year) *(month, day, year)*

In no event shall this delegation of parental rights be effective for more than six months. ____ / ____ / _____
(date signed)

_____ _____
(signature of parent or guardian) *(signature of parent or guardian)*

Allergies: _____

Chronic diseases or medical problems: _____

Medicines child is now taking: _____

Family Physician: _____ Telephone: _____

Medical Insurance Carrier or Government Program: _____

ID Number: _____ Member's Name: _____

Benefit Code: _____ Account Number: _____

Parent/Legal Guardian Contact Phone Number(s): _____