

PERMISSION TO TREAT CHILDREN

I (We), _____, am (are) the parent(s) or legal guardian of:

NAME	BIRTH DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I (We) grant authority to the people listed below to bring our child(children) in for sick appointments:

Please list parents here also:

NAME	ADDRESS	PHONE	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To consent to outpatient or inpatient medical/surgical treatment of any above named minor(s). Should his/her condition require treatment, the above named person having physical custody or responsibility for the care of the minor(s) in need may bring this consent to the physician or hospital. This permission may include transportation and/or admission to an appropriate healthcare facility.

I (We) understand medical or surgical treatment can include diagnostic laboratory or radiology testing, intravenous feedings, injections, blood transfusions, medical care, or surgery considered necessary in the situation. I (We) set no limitations on treatment of the above named minor(s) other than:

I (We) understand that reasonable attempts will be made to contact me (us), as well as the personal physician listed below, time and conditions permitting. This authorization is effective from the date of signature for 1 year.

Signature of parent/legal guardian

Signature of parent/legal guardian

Date

Relation to Child

Date

Relationship to Child