Authorization For Another To Consent To Treatment Of Children

As a parent or legal guardian of the following children:

Name_____ Birth Date_____

Name_____ Birth Date_____

Name_____ Birth Date_____

Name_____ Birth Date_____

I hereby authorize_____

Address_____

Phone #_____

Who is 18 years of age or older, to consent to any medical or surgical treatment of the above children when such person deems advisable parent or legal guardian cannot reasonably be located when the children are brought in for treatment. The above authorization will be effective as of _____ and will expire after _____ . (Total period by law will not exceed six months.) During this period, the parent or legal guardian of the above children will be at the following location(s):

Signature _____
Parent/Guardian

Parent/Guardian Phone # _____

Employer's Phone # _____

Is it okay to sign for immunizations? □ YES □ NO

Name of child _____
Chronic Illness or Allergies _____
Current Medications _____

Name of child _____
Chronic Illness or Allergies_____
Current Medications _____

Name of child _____
Chronic Illness or Allergies _____
Current Medications _____

Name of child _____
Chronic Illness or Allergies _____
Current Medications _____