AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT FOR MINOR CHILD LACKING CONSENT

Name of Child:	
Date of Birth:	
Parent(s) Name(s):	
Legal Guardian:	
Relationship to Child:	
Parent/Guardian Telephone # :	
Address of Child:	
Address of Parent or Legal Guardian:	
Emergency Contact #1 Name & Tel #s:	
Emergency Contact #2 Name & Tel #s:	
Pediatrician Name & Tel #:	
Family Physician Name & Tel #:	
Dentist & Tel #:	
Medications:	1. 2. 3.
Drug Allergies:	1. 2. 3.
Other Allergies:	1. 2.
Medical Problems:	1. 2. 3.
Past Surgeries:	1. 2. 3.
Date of Last Tetanus Shot:	
Insurance Information: • Carrier • Policy # • Group # • Member ID #	
Adult Person to Whom Parent/Legal Guardian authorizes to consent to treat: • Relationship to Child • Tel # • Address	
Physician and office/clinic authorized to rely upon this Consent:	

(I)/(We), the undersigned, parent(s)/person having legal custody/legal guardianship and the legal right to consent to the medical treatment of _____, a minor, do hereby authorize and execute this power of attorney to: _____, as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed in the State of Nevada on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

(I)/(We) authorize Dr. _____ and affiliated physicians and practitioners working in the same clinic/office to rely upon this Authorization.

(I)/(We) understand that the physician/practitioners who rely upon this Authorization are not required to perform medical treatment/services/care if they determine is not an emergency, or if they want the consent of me/us, as parent or legal guardian. This Authorization does not require a physician/practitioner to treat the above named child.

It is understood that this Authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. It is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her judgment, deem advisable.

(I)/(We) hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my)/(our) above-named agent(s) upon the completion of treatment.

This authorization shall remain effective until _____, 20___, unless sooner revoked in writing delivered to said agent(s) and the treating physician.

(I)/(We) acknowledge that I am/we are responsible for all charges in connection with care and treatment rendered to the child during this period, and agree to guarantee payment for services.

Name:	Signature:
Relationship to Child:	Date:

Name:	Signature:
Relationship to Child:	Date:

Witness Signature:	Printed Name
Date:	