Temporary Consent Authorization to Treat a Child

Procedure/Treatment _____
I (we)_____ Name(s) of Parent(s) or Guardian(s)
designate to _____ Name and address of designee

the power to consent to medical care for our child(ren) in our absence:

_____ _____
Name and age of child Name and age of child

_____ _____
Name and age of child Name and age of child

Parent(s)' phone number: _____

Child(ren)'s physician(s): _____

Physician's address and phone number: _____
_____

Interpreter Name (if used) _____
Medical insurance company: _____ Policy #: _____
Dates of expected absence from school/work _____ to _____

CHILD(REN)'S MEDICAL HISTORY

Chronic conditions_____

Medications that need to be given on a regular basis:

_____ _____
Child's Name Medication name, dosage, frequency

_____ _____
Child's Name Medication name, dosage, frequency

_____ _____
Child's Name Medication name, dosage, frequency

Allergies:_____
Dietary or other restrictions: _____

Document Released: 05/06/2010
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