# PERMISSION TO TREAT CHILDREN

I (We), ________________________________, am (are) the parent(s) or legal guardian(s) of: __________________________________ grant to ___________________________ the authority 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 health care 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 until the following date: _____________ (not to exceed 12 months from date of signature).

| | |
|---|---|
| x_________________________________ | x_________________________________ |
| **Signature of parent/legal guardian** | **Signature of parent/legal guardian** |

| | | | |
|---|---|---|---|
| __________ | ________________________ | __________ | ________________________ |
| **Date** | **Relationship to Child** | **Date** | **Relationship to Child** |

## Additional Information

Primary Care Physician ____________________________ Child's Address ________________________________

City _______________________ Phone _____________ City/State/Zip _________________ Phone _____________

Insured Work Place _____________________________ Spouse's Work Place ___________________________

Address __________________ Phone _____________ Address ______________________ Phone _____________

Other Contact __________________________________ Address/Phone ________________________________

Health Insurance Company _________________________________________________________________

Policy number __________________________________ Policy Group number ____________________________

Name of Policy Holder____________________________ Policy Holder date of birth: ________________________