After Hours
PEDIATRICS

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

I have legal custody of the children listed below.

I authorize and consent that _____ (hereafter "Supervising Adult") may summon any and all professional emergency personnel to transport and treat any child listed below. In addition, I authorize and consent that Supervising Adult may provide consent for any X-ray, anesthetic, blood transfusion, medication, or other treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his/her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on _____ and expiring on _____.

Mother/Guardian Name: _____ Father/Guardian Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Home Phone: _____ Home Phone: _____

Mobile Phone: _____ Mobile Phone: _____

Child #1 Name: _____ Child #3 Name: _____

Child #2 Name: _____ Child #4 Name: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Insurance Provider: _____ HMO/PPO: _____

Subscriber's Name: _____ Policy Number: _____

List medication being taken by each child (identify which child): _____

_____

_____

List allergies to medications of each child (identify which child): _____

_____

_____