AUTHORIZATION FOR NON-PARENTAL ADULT CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR

I, ______________________________, am the biological or adoptive parent of ______________________, born on ______________________________.

I hereby authorize ____________________________________, to make all health care decisions pertaining to my child, ________________________________, including consent for all routine or ordinary medical care and treatment, emergency medical care and treatment of any kind, and elective health care, including elective surgical procedures, x-ray examinations or laboratory procedures, and the administration of anesthesia.

Any health care provider relying upon this consent for the care and treatment of my child, ____________________________________, may do so to the same extent and in the same manner as if I had personally consented to such care or treatment.

This Authorization may be withdrawn only in writing, and shall not be deemed withdrawn until such time as my child's health care providers receive actual notice that I have withdrawn my consent as stated above.

❑ My child does not have any chronic diseases or drug allergies
❑ My child has a chronic disease or drug allergies. *Explanation:*

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This authorization shall remain in effect until _____________________________, or unless sooner withdrawn in writing by the undersigned.

______________________ Date	______________________________________ Parent or Legal Guardian's Signature
______________________ Relationship to Patient	______________________________________ Witness Signature

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Parent's or Legal Guardian's Address and Phone Number

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex:

NON-PARENTAL ADULT CONSENT FOR TREATMENT

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