# PERMISSION TO TREAT CHILDREN

*I (We), _____, am (are) the parent(s) or legal guardian of:*

| *NAME* | *BIRTH DATE* |
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*I (We) grant authority to:*

| *NAME* | *ADDRESS* | *PHONE* | *RELATIONSHIP* |
|---|---|---|---|
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*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 healthcare 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 for 1 year.*

| | |
|---|---|
| _____ | _____ |
| **Signature of parent/legal guardian** | **Signature of parent/legal guardian** |
| _____ _____ | _____ _____ |
| **Date Relation to Child** | **Date Relationship to Child** |