Take Care of Them!

On those occasions when you will not be available to care for your child in either an emergent or non-emergent health situation, there is a form that you can complete to authorize care by another individual or individuals.

Planning ahead for any unexpected event will give you peace of mind while you are away and eliminate any delays in treatment, avoiding unnecessary anxiety and discomfort for your child.

Following completion of the form, give it to the adult(s) you have designated and explain its use. Make sure they know that they should bring the form with them to the care center in the event that medical care will be needed.

McLaren
MEDICAL GROUP

Don't Leave Them Without It!

Parental Authorization to Treat Minor in Absence of Parent/Legal Guardian

PARENTAL AUTHORIZATION TO TREAT MINOR IN ABSENCE OF PARENT/LEGAL GUARDIAN

I understand that if my child needs emergency or non-emergency medical services, I, as a parent or legal guardian, must give permission.

The following information relative to my child, _____, is provided in the event that treatment is needed in my absence.
Print Name/Birthdate

MEDICAL/INSURANCE DATA

Allergies: _____

Medicines: _____

Medical Problems: _____

_____

Insurance Information: Subscriber's Date of Birth _____

Company _____ Subscriber's SS# _____

Policy/Group/Certification Numbers _____

_____

APPOINTMENT

I/We, being the parent(s) or legal guardian(s) of the identified minor, do hereby appoint:

1) Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2) Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

to act in my/our behalf in authorizing medical care for the identified minor during the period of my/our absence, from:

_____ through _____
Month Day Year Month Day Year

AUTHORIZATION

_____ _____
Signature of Parent/Guardian Date Signature of Parent/Guardian Date

_____ _____
Address of Parent/Legal Guardian Address of Parent/Legal Guardian

_____ _____
Signature of Witness Date Signature of Witness Date

_____ _____
Signature of Appointed Representative Date Signature of Appointed Representative Date

IF AVAILABLE, TELEPHONE NUMBER WHERE PARENT MAY BE REACHED: _____

PARENTAL AUTHORIZATION TO TREAT MINOR IN ABSENCE OF PARENT/LEGAL GUARDIAN

Patient Name (Minor):

Date of Birth: