CONSENT FOR MEDICAL TREATMENT OF MINORS IN ABSENCE OF PARENT(S) OR GUARDIANS

Name of Minor: ____ Age: _____ DOB: ________________________

Address: ____

Telephone: ________________________ Email: ____

I, ______________________________________, am one of the parents of the minor named above. I know that for the following reasons, I may not be available to personally authorize medical, dental, surgical care and hospitalization for said minor. Those reasons are:

____

____

____

Please read and initial:

I hereby give my consent and authorization for any emergency or non-emergency diagnostic procedure, medical, dental, surgical care and hospitalization that any health care provider so determined as advisable, in the best judgement of said health care provider including, but not limited to, any physician, dentist or hospital personnel providing health care to the minor.

_____ **Initials**

In my absence, I would like the health care provider to discuss the matter with the persons designated below. I authorize those persons, insofar as the law of California permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

_____ **Initials**

I hereby authorize the healthcare provider to discuss in full with those persons designated any medical information that is required to help the input of the persons so designated.

_____ **Initials**

I hereby hold harmless any physician, dentist, hospital or hospital personnel, or other healthcare provider rendering such are to the minor form of any liability resulting in the failure to obtain consent from me as the parent of the minor and from any other reason. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

_____ **Initials**

I have put the important medical facts, if any, on the next page of this consent. The medical facts are intended to help a doctor, medical personnel, or other healthcare provider in deciding what treatment is to be given but is in no way intended to restrict the authorization and consent hereby given.

_____ **Initials**

I hereby appoint one person from the following list to be chosen in the order of priority listed when the persons in the prior listings are not reasonably available, willing or competent to participate in the health care decision-making concerning the minor.

_____ **Initials**

Additional Names (Priority from top to bottom):

Name: ____ Phone: ______________________________

Address: ____

Name: ____ Phone: ______________________________

Address: ____

The period of time over which this authorization exists is as follows:

Beginning at 12 midnight on: ____
Month Day Year

Ending at 12 midnight on: ____
Month Day Year

It's intended that this document be presented to the physician, dentist, or appropriate hospital or medical representative at such time that the medical, dental, surgical care or hospitalization shall be authorized.

It is intended that this authorization relieve the physician, dentist or any healthcare provider or any hospital or institution in which such care is given from any liability resulting from the failure of me, as parent, or any other person, from signing a consent or authorization to render such care. It is the intent that the person or persons appointed herein shall be able to act in my stead in making decisions.

Signature of Parent Date	Signature of Parent Date
Address	Address
City, State Zip	City, State Zip
Home Phone Work Phone	Home Phone Work Phone

Allergies: ____

Medications: ____

Last Tetanus Shot: ____

Medical History or other pertinent facts that should be known:

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For information only, minor's usual dentists and doctors for necessary consultations:

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