PREVEA health

MEDICAL TREATMENT CONSENT FOR MINORS

DEAR PARENT OR GUARDIAN:

Please present this card to your child's physician if your child will be seeking medical treatment in your absence. In non-emergency situations, it is necessary to obtain your consent prior to providing treatment to your child. Providing us with this valuable information may prevent delay of treatment for your child. This form should be provided to your child or your child's caretaker in your absence. In the event emergency treatment is necessary, this authorization shall be considered acceptable by any facility where your child is receiving treatment.

I hereby authorize care be provided for my child _____ for the following:
(Child's Name)

- ❑ Emergency care in my absence
- ❑ Necessary care (including labs, X-rays or medications) related to his/her _____ appointment with _____
(Date)
(Provider's Name)

In my absence _____ is estrusted to make emergency medical decisions for my child on my behalf until _____ if I am not able to be reached.
(Name)
(Date)

Signature of Parent/Guardian _____

Print Name _____ Date _____

PATIENT INFORMATION

Child's Name _____ Date of Birth _____

Child's Address _____

Child's Telephone Number _____ Child's Physician _____

Medications Child is taking _____

My child is allergic to _____

Child's Health Insurance Company and Policy Number _____

Other Special Information _____

Parent/Guardian Names _____

Parent/Guardians may be reached at _____
(Phone Numbers)

_____
(Address)

If Parent/Guardian is unavailable, contact _____
(Name/Phone)

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