

TEMPORARY AUTHORIZATION TO CONSENT TO TREAT A CHILD

I (we) _____

name and address of parents

designate to _____

name and address of designee

the power to consent in our absence to medical care for our child/ children

Name(s) of children and ages

Parent(s) phone numbers _____

Child(ren)'s Physician _____

Physician Address and Phone _____

Medical Insurance +policy # _____

Dates of expected Absence _____

CHILD(REN)'S MEDICAL HISTORY

Chronic Conditions _____

Medications _____

Allergies _____

Signature of Parent _____