TEMPORARY AUTHORIZATION FOR MINOR ACCOMPANIED BY INDIVIDUAL NOT PARENT/GUARDIAN

Minor's Name:____

I am aware that my child may require treatment when I am unable to be present.

In my absence, I give ____
(Name of adult individual and relationship to minor)

my permission to authorize treatment for my child, ____________________________
(Name of minor)

OR

In my absence, I give ____
(Healthcare provider or healthcare facility)

my permission to examine and provide emergency treatment to my child,

____.
(Name of minor)

In addition, the provider/facility has my permission to refer my child's emergent care to the appropriate service or provider to render optimal care for the treatment of illness or injury.

This agreement begins ______________________ and ends ______________________.
Date/Time **Date/Time**

____
Parent/Guardian/Legal Representative Signature/Date/Time

____
Print Parent/Guardian/Legal Representative's Name

____
Legal Representative's Relationship to Parent/Guardian

____
Witness Signature/Date/Time

____
Print Witness's Name

HEALTH, PHYSICAL, AND INSURANCE INFORMATION

Please complete:

Minor's date of birth: _____________ Weight: _________________ Height: __________________
Allergies: ____
Medications: ____
Previous surgeries: ____
Chronic illnesses: ____
Other pertinent health information: ____

Insurance carrier: _______________ Policy # ________________ ID # ____________________

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This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).

SAMPLE