MIDLAND FAMILY PHYSICIANS, P.C.

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, (We) _____ (name) and _____ (name)

of _____ (city), _____ (county), _____ (state), do hereby state that I am (we are) the parent (s) or legal guardian (s) of:

_____ (name), a minor, age _____, DOB: _____ (date)

who resides with me (us) at _____ (address).

I (We) authorize _____ (name), an adult who resides at _____ (address) in the city of _____, county of _____ state of _____

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor during the period(s) of my/our absence from:

_____ (month) _____ (day) _____ (year) through _____ (month) _____ (day) _____ (year).

In no event shall this delegation of parent rights be effective for more then six months.

_____ Signature of parent or guardian _____ Signature of parent or guardian

_____ (date)

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, Dental, surgical care or hospitalization may be required.

Allergies: _____

Chronic diseases or medical problems: _____

Medicines child is now taking:_____

_____

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Family Physician_____Phone #_____

Medical Insurance Carrier or Government Program _____

ID #_____Members Name _____

Benefit Code _____ Account Number _____

Parents may be reached as follows: _____

_____

This is a legal document. Take it with you and give it to the physician, dentist or hospital representative so that necessary treatment can be given to a child whose parents cannot be contacted for permission.