Authorization to Consent to Medical Treatment of a Minor

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. Unless a child's injuries are life-threatening, medical personnel and physicians cannot treat him or her without legal parental or guardian consent. As a result, your child may suffer unnecessary discomfort while waiting for you to be reached to approve stitching a cut or setting a broken arm.

Minor Full Legal Name: _____
Home Address: _____
Date of Birth: _____ Gender: Female_____Male_____

Information for Medical Treatment & Location of Practice:
Beyond Urgent Care North Haven CT
79 Washington Ave, North Haven, CT 06473
Physician's Phone #: (203) 456 - 8000

Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications: _____
Allergies (Other): _____
Please note all conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information:
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S):

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: _____. Signed this _____day of_____, 20__.

Parent / Legal Guardian Signature: _____Printed Name: _____

Witness Signature: _____Printed Name:_____