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CONSENT FOR EMERGENCY TREATMENT OF MINORS IN ABSENCE OF PARENT(S) OR LEGAL GUARDIAN

Name of Minor: _____ Age: _____ Birth date: _____

Address: _____

_____

_____

Home Phone: ( ) _____

I, the undersigned, am one of the parents of the minor named above. I know that for the following reasons I may not be available to personally authorize medical, dental, surgical care and hospitalization for said minor. Those reasons are:

_____

_____

_____

I hereby give my consent and authorization for any emergency or non-emergency diagnostic procedure, medical, dental, surgical care and hospitalization that any health care provider so determined as advisable, in the best judgment of said health care provider including, but not limited to, any physician, dentist or hospital personnel providing health care to the minor.

In my absence, I would like the health care provider to discuss the matter with the persons designated below. I authorize those persons, insofar as the law of New York State permits me to do so, to enter into the decision, to convey to the provider my consent, and to consent to said treatment.

I hereby authorize the health care provider to discuss in full of those persons designated any medical information that is required to help the input of the persons so designated.

I hereby hold harmless any physician, dentist, hospital or hospital personnel, or other health care provider rendering such care to the minor from any liability resulting from the failure to obtain consent from me as parent of the minor and from any other person. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

I have put the important medical facts, if any, on the reverse side of this document. The medical facts are intended to help a doctor, medical personnel, or other health care provider in deciding what treatment is to be given but is in no way intended to restrict the authorization and consent hereby given.

I hereby appoint one person from the following list to be chosen in the order of priority listed when the persons in the prior listings are not reasonably available, willing or competent to participate in the health care decision-making concerning the minor:

Names, Addresses and Phone Numbers of those persons I am so authorizing are as follows:

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

Name: _____ Address: _____

Phone: _____ _____

The period over which this authorization exists is as follows:

Beginning at 12 midnight on: _____
Month Day Year

Ending at 12 midnight on: _____
Month Day Year

It is intended that this document shall be presented to the physician, dentist, or appropriate hospital or medical representative at such time that the medical, dental, surgical care or hospitalization shall be authorized.

It is intended that this authorization relieve the physician, dentist, or any health care provider or any hospital or institution in which such care is given from any liability resulting from the failure of me, as parent, or any other person, from signing a consent or authorization to render such care. It is the intent that the person or persons appointed herein shall be able to act in my stead in making decisions.

_____		_____	
Signature of Parent	Date	Signature of Parent	Date
_____		_____	
Address		Address	
_____		_____	
City/State	Zip	City/State	Zip
_____		_____	
Home Phone	Work Phone	Home Phone	Work Phone

Allergies: _____

Medications: _____

Last Tetanus Shot: _____

Medical history or other pertinent facts that should be known: _____

_____

_____

_____

_____

For information only, I am listing said minor's usual dentists and doctors so they may be consulted if that is deemed necessary by anyone: _____

_____