Mercer Health

Mercer Health
Medical Group

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

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor, where the minor is not accompanied by either parents or legal guardians and it may not be feasible or practical to contact them.

I do hereby state that I am the parent or legal guardian of _____.

I grant my authorization and consent for _____ ("Designated Adult") to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my child. Such care and treatment shall include but not be limited to X-ray, anesthetic, blood transfusion, medication, or other medical 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 in the state in which such treatment is to occur. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period. 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: **(select one)**

☐ indefinitely until revoked

☐ start _____ stop _____

_____ _____

Parent/Guardian Signature Date Witness Signature Date

_____ _____

Printed Name Printed Name

Minor's Information

Full Legal Name: _____

Home Address: _____

Date of Birth:_____ Parent/Guardian Phone #: (_____)_____

Physician's Name and Address: _____

_____

Physician's Phone # (if known): (_____)_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications:_____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment/medications: _____

_____

Note any other significant medical information: _____