

MEDICAL CONSENT FOR TREATMENT OF A MINOR

In the event my child needs medical treatment and the treating facility cannot reach me, I authorize the following adult(s) to give consent for medical treatment, including emergency surgery:

Name of authorized adult: Justin Mourn

Name of authorized adult: Laura Mourn

INFORMATION ABOUT MY CHILD:

Name: _____ Date of Birth: _____

Address: _____

Chronic illnesses or allergies: _____

Current Medications: _____

Date of last tetanus shot: _____

Child's personal physician: _____ Phone: _____

Health insurance company: _____

Health insurance group #: _____

Person who will be responsible for payment: _____ Phone: _____

INFORMATION ABOUT ME:

I am the child's: parent stepparent legal guardian other _____

Home address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

In case of emergency, the following person would know how to reach me:

Name: _____ Home Phone: _____ Other Phone: _____

PERIOD OF AUTHORIZATION:

I want this consent to be in effect from (date) Feb. 1, 2009 to (date) Dec. 31, 2009.

I understand that the persons authorized by me must be at least 18 years old and must be prepared to verify their identification if my child needs medical treatment. I also understand the authorized persons must present this form for treatment.

My signature: _____ Date: _____

Signature of witness: _____ Date: _____

(witness must be someone other than a family member)