CONSENT TO TREATMENT OF A MINOR WHEN PARENTS/GUARDIANS ARE TEMPORARILY UNAVAILABLE

The undersigned parent(s) or guardian(s) of _____, a minor, authorizes _____ to consent to treatment of _____ including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not available in person, or immediately by a telephone call, to the listed number(s) _____
_____

It is understood that this Consent is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the physician to diagnose and treat the minor in the parent's/guardian's absence.

1. Persons to contact in an emergency:

   a) _____ Phone: _____

   b) _____ Phone: _____

2. Medical concerns or any learning disabilities: _____
   _____

3. Known allergies: _____
   _____

4. Health Insurance Plan (name and number):
   _____

Parent(s) Name:

Father: _____ Mother: _____

Business Phone: _____ Business Phone: _____
Home Phone: _____ Home Phone: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Signature: _____ Date: _____