Stormont Vail Health

Cotton O'Neil

1083

Parental Authorization for Medical Treatment

I hereby authorize_____ to approve medical treatment for
(Caregiver)

My child _____ whose date of birth is_____
(Child's Name) (Month, Day, Year)

(Medical treatment may include diagnostic studies and interventions deemed necessary or advisable by the physician providing care to my child.)

This Authorization is to cover a period of time from _____ to _____
(Date) (Date)

_____ _____
Date of Last Tetanus Booster **Allergies**

Family Physician/Pediatrician_____ **Physician Phone Number** _____

Medications_____

Health Problems_____

Insurance Information_____
(Please attach a copy of your insurance card.)

Date_____ **Parent/Guardian Signature**_____

Print Parent/Guardian Name _____

Parent/Guardian Address _____

Parent/Guardian Phone Number_____

This document **MUST** be dated and signed in the presence of two (2) witnesses **OR** acknowledged by a notary public.

(1) Witnesses – two (2) individuals of lawful age who are not the caregiver or child by blood, marriage, or adoption and not financially responsible for the child's health care.

Witness Name (Printed) _____ Witness Name (Printed) _____

Signature _____ Date_____ Signature _____ Date_____

Address_____ Phone_____ Address_____ Phone_____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20_____.

Signature of Notary Public _____My appointment expires: _____