Stormont Vail Health

Cotton O'Neil

1083

Parental Authorization for Medical Treatment

I, the undersigned, parent(s) or legal guardian of ___________________________, whose date of birth is
(child's name)

____________________ do hereby authorize the medical providers of Stormont Vail Health to perform
(Month \ Date \ Year)

medical treatment, which may include, procedures, immunizations, diagnostic studies and interventions deemed necessary or advisable by the health care providers of Stormont Vail Health providing care to my child when accompanied by any of the following named adult persons over the age of 18, who are authorized to provide consent for such treatment on my behalf:

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

Adult's name: _________________________________ Relationship to the child: __________________
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Other)

This authorization expires on the child's 18^{th} birthday unless otherwise stated below. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.

Date_____________ Parent/Guardian Signature____

Print Parent/Guardian Name ____

Parent/Guardian Address ____

Parent/Guardian Phone Number____

****Optional** Time Limitation**

This Authorization is to cover a period of time from __________________________ to __________________________
(Start Date) (End Date Not to Exceed 18^{th} Birthday)

Please return this form to your child's health care provider to have it scanned into your child's electronic health record for future reference. (Note: If you have more than one child, each child must have a separate authorization.)