Family Physician

Telephone

Medical Insurance Carrier or Government Program

ID Number

Member's Name

Benefit Code

Account Number

Parents may be reached as follows:

This is a legal document. Take it with you and give it to the physician, dentist or hospital representative so that necessary treatment can be given to a child whose parents cannot be contacted for permission.

MidMichigan Health
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

www.midmichigan.org

MKG00062 | 10/14

Consent For Medical Treatment Of a Minor Child

MidMichigan Health
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

I, (We) _____ and _____
(name) (name)

of _____, _____, _____, do hereby state that
(city) (county) (state)

I am (we are) the parent(s) or legal guardian(s) of:

_____, a minor, age _____, born _____
(name) (date)

who resides with me (us) at _____
(address)

I (We) authorize _____, an adult,
(name)

who resides at _____
(address)

in _____, _____, _____
(city) (county) (state)

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s) during the period(s) of my/our absence from:

_____ through _____
(month / day / year) (month / day / year)

In no event shall this delegation of parental rights be effective for more than six months. _____
(date)

_____ _____
Signature of parent or guardian Signature of parent or guardian

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, dental, surgical care or hospitalization may be required.

Allergies: _____

Chronic diseases or medical problems: _____

_____

Medicines child is now taking: _____

_____

_____