TRACESIDE
DERMATOLOGY & ALLERGY

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

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

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

- Name: _____Relationship to Child: _____Phone: _____
- Name: _____Relationship to Child: _____Phone: _____
- Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____

3. Known allergies: _____

Name of Parent or Legal Guardian: _____

Relationship to Child: _____

Contact Number(s): ( )_____-_____ or ( ) _____-_____

Address: _____ City, State, Zip: _____

Signature: _____ Date: _____/_____/_____

This Consent is effective until withdrawn in writing by the child's parent or guardian.