Authorization to Consent to Treatment of Minor

I, [name], am the [parent/guardian/managing conservator] of [name of minor], a minor child, and have the power to consent to medical treatment for [him/her]. [Include if applicable: [Name[s]] [is/are] [name of minor]’s [other parent/parents].] I authorize and appoint [name] as my agent to consent to medical treatment of the minor when I cannot be contacted to so consent, such medical treatment to include, without limitation, X-ray examination; anesthetic treatment; medical, dental, or surgical examination or treatment; and general hospital care. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

SIGNED on [date].
Authorization to Consent to Treatment of Minor

[Name of parent/guardian/managing conservator]

Child’s name: ________________________________

Birth date: ________________________________

Last tetanus immunization: ________________________________

Allergies: ________________________________

Hospitalization insurance co.: ________________________________

Pediatrician: ________________________________

Type of credit card: ________________________________

Credit card number: ________________________________

Name on credit card: ________________________________

Expiration date: ________________________________