# AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS

(ANYONE UNDER THE AGE OF EIGHTEEN)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Name of Minors | Birthdate | Date of last | Family Physician | Allergies |
| --- | --- | --- | --- | --- |
|   |   | Tetanus | Name & Phone # |   |
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I/We being the parent(s) or legal guardians(s) of the above named minor(s), do hereby appoint:

## Blooming Grove Day Care Center

**Rt 94/ Old Dominion Rd Blooming Grove, NY 10914**

**845-496-6663**

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

**Month\_\_\_\_\_\_\_ Day\_\_\_\_\_ Year\_\_\_\_\_\_ THROUGH Month\_\_\_\_\_\_ Day\_\_\_\_\_ Year\_\_\_\_\_\_\_**

This document shall be presented to a physician, dentist or appropriate hospital representative at such time an emergency medical, dental, surgical care or hospitalization may be required. This document shall not be construed as consent to medical, dental, or surgical treatment of an elective nature if such treatment can be postponed until I am available to consent to such care personally. Treatment shall be considered elective if in the treating physician’s judgment, it can be delayed until I am available to consent without serious negative impact to my child’s health and welfare.

I agree that I am responsible for the costs and expenses for medical, dental, or surgical care and hospitalization rendered to the above named minor at the direction of the individual(s) I/we have appointed herein.

Hospitalization coverage for the above-named minor(s):

### Name of Insurance Company or Government Program ID or Policy Number

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**Address of Ins. Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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#### Authorization for Emergency Treatment of Minors

**(Anyone under the age of eighteen)**

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**Parent/Legal Guardian’s Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name**

When in the Physician’s judgment, an emergency exists and your child is in immediate need of medical attention that any delay in treatment would result in increased risk to your child’s life or health, parental consent will not be required. In all other cases, no other treatment will be provided until parental consent is obtained. For those situations in which other than a “true emergency” exists, you can avoid unnecessary anxious moments for your child by making sure that the person in whose care you left the children knows where you can be reached while you are away from home or, for those times when it would be difficult to contact you, you can authorize other adults to give permission for necessary medical or dental care for your child.

This is a legal document. With it you may appoint other adults to consent to medical treatment for your minor children when you cannot be reached to give such consent. You can appoint relatives, friends, teachers, clergy, neighbors-anyone who is over eighteen years of age and who can be responsible for your children when you are away from them. This is especially important for times when you know it will be difficult to reach you.

Fill out this form, or one similar to it, and give it to the adult(s) who can be responsible for your child while you are away. If your child needs medical or dental attention, the responsible adult should present this document to the appropriate person- physician, hospital representative, or dentist. The responsible adult may then consent to treatment that, in the physician’s judgment, should not wait until you are available to consent in person. This form does not authorize the appointee to give consent to elective medical or dental treatments.

\*NOTE; THIS FORM MUST BE MADE PART OF THE PATIENT’S MEDICAL RECORDS.