

College Park Family Care Center

PERMISSION FOR MEDICAL TREATMENT

In the event of our absence or unavailability, _____
Name of Individual(s)

is authorized to give consent for the medical treatment of our minor child/children:
(list names and ages of each)

We realize that our child/children might be in need of immediate medical treatment to relieve pain or to begin the healing processes even though his/her life might not be in danger.

This consent is specifically given to cover the period from _____ to _____,
during which we may be unavailable to consent to treatment of our minor child/children.

_____	_____	_____
Date Signed	Father	Mother
_____	_____	
Physician Preferred	Parents' Home Address	
_____	_____	
Hospital Preferred	Phone Number	
_____	_____	_____
Last Tetanus Toxoid	Health Insurance Company	Policy Number

Drug allergies or medications pertaining to each child: