



SUBSTITUTED CONSENT FOR TREATMENT OF MINORS & INCOMPETENTS

(NOTE: Efforts should still be made to contact parent/guardian before providing treatment.)

I, the undersigned parent/guardian of _____,
(minor's name and date of birth)

in the event that I cannot be contacted through reasonable efforts, hereby empower and grant to

_____ permission to consent to and authorize
(insert name of third party)

medical and hospital treatment for my above-named child/ward. This authorization shall be valid for the

period of time commencing on _____ and ending

_____. I do hereby indemnify and hold harmless the physicians, hospital and other persons who act in reliance upon this authorization.

Executed this _____ day of _____, _____.

Witness Parent/Guardian

Information:

Parent/Guardian can be located at the following address/phone number: _____

Names/Addresses of family doctor, pediatrician, dentist: _____

Any known allergies: _____

Insurance Information:

Company _____

Policy Number _____

Coverage Code _____