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

The undersigned parent(s) of _____, a minor, authorizes
*(minor's name)*

_____ (babysitter, guardian, step-parent, etc.)
*(name of person receiving parental consent)*

to consent to treatment of _____ including, but not limited to,
*(minor's name)*

emergency, x-ray, anesthetic, or surgical services when I am not available in person, or immediately by a telephone call, to _____.
*(parents' telephone #)*

It is understood that this Consent is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the physician to diagnose and treat the minor in the parent's/guardian's absence.

1. Persons to contact in an emergency:
   a. _____ Phone: _____
   b. _____ Phone: _____
2. Medical concerns or learning disabilities:

   _____

   _____
3. Known allergies:

   _____

   _____

Parent(s) Name:

| | |
|---|---|
| Father: _____ | Mother: _____ |
| Business Phone: _____ | Business Phone: _____ |
| Home Phone: _____ | Home Phone: _____ |
| Address: _____ | Address: _____ |
| City/State/Zip: _____ | City/State/Zip: _____ |

Signature: _____ Date: _____

*This consent shall remain effective for 12 months or until written revocation, signed by the minor's parent(s) of the Consent is received by the physician/clinic, whichever occurs first.*