Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

Authorization for Medical Treatment of Minors.

If your child needs medical or hospital services, you as a parent/guardian must give permission/consent for treatment.

A child may be treated without parental consent when a clinician determines a true emergency exists. That means the clinician determines the child needs immediate medical care and that an attempt to obtain parental consent would result in delay which would increase the risk to the child's life or health.

If we can reach you, you can give verbal permission, however, if you cannot be reached you can use this form to authorize other adult(s) to be able to act on your behalf. They can then act for you by permitting your child to be treated when care is needed. With this document you can prepare for routine and unexpected care your children might need when you are away from home and know you will be hard to reach. You may appoint relatives, teachers, clergy, neighbors-anyone who is over 18 years of age-to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form carefully.
Have your signature witnessed by an adult different from the person you are making responsible for your children.

After you complete this form, give it to the adult(s) you have named to act on your behalf. If your child needs medical treatment, the responsible adult(s) should present this document to the appropriate person- the clinician, nurse or hospital representative.

Name of Minor:	Birthdate:	Identify Allergies or Special Conditions

I/We, being the parent(s) or legal guardian (s) of the above names minor(s), do hereby appoint,

Name:	Address:	Phone:

To act in my/our behalf in authorizing routine and/or unexpected medical and surgical care and hospitalization for the above named minor during the period of my/our absence, from:

Month	Day	Year	through		Month	Day

This document shall be presented to a clinician, nurse or appropriate hospital representative at such times as routine and/or unexpected medical or surgical care of hospitalization may be required.

Parent/Guardian	Parent/Guardian
Signature:	Signature:
Address:	Address:
Date:	Date:
Witness:	Witness:

Hospitalization Coverage for above Named Minor(s)

Insurance company:	I.D. or Contact Number:
Family Physician:	Phone Number.
Name and Phone Number:	