CHILD HEALTH CARE ASSOCIATES

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PHILIP REMILLARD, M.D., FAAP
KRISTINE JOSEPH, M.D., FAAP
SEAN O'MALLEY, M.D., FAAP
TRACY MASSA, M.D., FAAP
THOMAS SCOTT, M.D., FAAP
HANNAH THORNTON, CPNP, IBCLC
MOSHE ROBERTS, MD, FAAP
VICTORIA SMITH, FNP
ARLINDA NEWELL, CPNP
KAYLA DELMAR, D.O., FAAP

Authorization for Healthcare and Treatment of Child Without Parent Present

It is necessary at times to designate a specific individual to consent to medical treatment for your child or other relative. This is especially important if an emergency arises when you are away.
This document can be presented to a physician, or appropriate hospital representative when emergency or non-emergency treatment for illness or injury is necessary.

1. I, _____, the parent/legal guardian of _____, hereby designate and authorize _____ to act in my place and stead while I am unavailable during the time period _____to _____(maximum 1 year) to give permission for the health care and treatment of my child.

2. I authorize the physicians of Child Health Care Associates and give permission for healthcare and treatment of my child _____ without a parent being present.

3. This authorization includes, but is not limited to, consent for physical examination, medical treatment, minor medical procedures and any emergency care and treatment where a delay in reaching me would endanger or seriously enhance the risks to my child. Other treatment and/or procedures that I authorize consent to be given are:
_____
(list any additional treatments or procedures)

4. **This authorization also includes injections/vaccinations.** I understand by signing this form, the person designated above will be authorized to sign for any injections/vaccines on my behalf unless otherwise noted.

_____
Parent/ Guardian Name (Print)

_____ _____
Parent/Guardian Signature Date