

CONTINUING CONSENT TO MEDICAL TREATMENT OF A MINOR

I _____ do hereby state that I am the natural parent or legal guardian having custody of _____ a minor, age _____, born on _____, in the state of _____, who resides with me at my residence of _____.

I designate and appoint the following person(s) to authorize treatment for the above minor child:

_____, an adult, who resides at _____; or
_____, an adult, who resides at _____; or
_____, an adult, who resides at _____.

The above named person(s) may authorize the following routine or emergency medical care for my child: x-ray, examination, anesthetic, medical or surgical diagnosis or treatment. Emergency care and surgical treatment are authorized under the provisions of this document only when efforts to contact me have been unsuccessful. This care is to be rendered under the general or special supervision and the advice of any physician, surgeon, physician assistant, or nurse practitioner, licensed in the State of Arizona when the need for such treatment is clear.

I authorize routine care for my child when initial care for the same condition has been authorized by my signature or by the person acting under the authority granted by this document. I understand that I am financially responsible for the above name minor.

This consent shall remain in effect for one year from date of signing, unless revoked in writing and delivered to this facility at an earlier date.

Minor's Primary Physician: _____

Minor's Allergies: _____

Minor' Medications: _____

Print Name: _____ Signature: _____

Dated on: _____