Mt. Ascutney Hospital and Health Center

Consent to Treat Minor in Parent/Guardian's Absence

I, _____ hereby give _____,
(parent/guardian's name) *(Name and Relationship to Child)*

_____ and _____
(Address) *(Phone Number)*

authorization to consent for treatment for my child,

_____ _____
(Name of Child) *(Child's Date of Birth)*

_____ _____
(Child's Mailing Address) *(Child's Home Phone Number)*

effective for the dates of _____thru _____.

_____ _____ _____
(Parent/Guardian's Signature) *(Phone number(s) where I can be reached)* *(Date)*

Current Medications/Dosages: _____

Known Allergies: _____

Date of Last Tetanus: _____

Other Comments: _____

Pediatrician Contact Information:

_____ _____
(Name of Pediatrician) *(Address of Pediatrician)*

(____) _____
(Phone Number of Pediatrician)

Insurance Information: *(If possible please attach a copy of the front and the back of the insurance card)*

_____ _____
(Name of Company) *(Company Address)*

(____) _____ _____ _____ _____ _____
(Company Phone Number) *(Guarantor's Name)* *(Account Number)* *(Group Number)*