UTHealth East Texas Physicians

Patient Name: _____

Patient MRN: _____

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical care, or health or hospital services, you as parent/guardian must give permission. It is the law. In an emergency, your child can only be treated without your consent if a physician determines that your child's life or health is at risk. That is why you should complete this Medical Treatment Authorization form today. You can prepare for the unexpected by giving other adults permission to authorize necessary treatment for your child during your absence. By filling out the form, you may legally appoint anyone over 18 years of age – relatives, teachers, baby sitters, friends – to take this responsibility. Complete the form carefully and have your signature witnessed by an adult other than the one you are authorizing. Give a copy of the completed form to your physician and to the adult(s) you have names to act on your behalf. If your child needs treatment, the authorized adult should present this document to the physician or hospital representative.

NAME OF MINOR: _____ **BIRTHDATE:** _____

ALLERGIES, SPECIAL CONDITIONS, OR MEDICATIONS: _____

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

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER: _____ AND

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER: _____

To act on my/our behalf in authorizing medical care, surgical care, and hospitalization for the above names minor(s) during the period of my/our absence:

FROM (MONTH/DAY/YEAR): _____ through (MONTH/DAY/YEAR): _____ OR

FROM (YEARS OF AGE): _____ through (YEARS OF AGE): _____

This document shall be presented to a physician or appropriate hospital representative at such time as medical care, surgical care, or hospitalization may be required.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

ADDRESS: _____ TELEPHONE NUMBER: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

ADDRESS: _____ TELEPHONE NUMBER: _____

WITNESS SIGNATURE: _____ DATE: _____

ADDRESS: _____ TELEPHONE NUMBER: _____

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR / INSURANCE COMPANY OR GOVERNMENT PROGRAM: _____

NAME OF FAMILY PHYSICIAN/PEDIATRICIAN: _____

ADDRESS: _____ TELEPHONE NUMBER: _____