Chase County Community Hospital and Clinic

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

I/We the undersigned, _____
Parent's Name(s) and Contact Information

_____,do hereby delegate to:

Name:_____Relationship:_____Contact Information:_____

Name:_____Relationship:_____Contact Information:_____

Name:_____Relationship:_____Contact Information:_____

Name:_____Relationship:_____Contact Information:_____

Name:_____Relationship:_____Contact Information:_____

The power to give consent to medical procedures, care treatment, and medications for the following minor dependents:

NAME:_____
DOB:_____
GENDER:_____
ALLERGIES:_____

NAME:_____
DOB:_____
GENDER:_____
ALLERGIES:_____

NAME:_____
DOB:_____
GENDER:_____
ALLERGIES:_____

This delegation is made for a period of_____commencing on the date of_____.

Dated_____

Parent_____

Parent_____

Witness_____