BW PRIMARY CARE

Bridge to Wellness

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A CHILD

I, _____ of _____

(Parent or Legal Guardian) (Street Address)

_____, _____, _____, _____

(City) (State) (Zip Code) (Phone Number)

_____, _____, _____

(Work Phone) (Cell Phone) (Email Address)

Make oath and say that I am the lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

CHILD'S INFORMATION

_____, _____, _____ and residing at

(Name) (Sex) (Date of Birth)

_____

(Street Address, City, State, Zip Code)

I hereby authorize and appoint _____**, of**

(Name)

_____ **as my agent.**

(Street Address, City, State, Zip Code)

I hereby authorize and appoint _____**, of**

(Name)

_____ **as my agent.**

(Street Address, City, State, Zip Code)

My agent may consent in my child's medical examination and treatment. Such treatments may include but are not limited to the following:

- Transportation by Ambulance
- Examination
- X-rays
- Diagnoses
- Hospitalization
- Anesthesia
- Medicaton
- Vaccines
- Laboratory Tests
- Procedures

I give this consent freely and knowingly in order to provide for the child and not as a result of pressure, threat, or payments by any person or agency.

This consent will remain in effect until it is revoked by notifying my child's medical, mental health care, and insurance providers, in writing, and the agent named above that I wish to revoke it.

Any questions or concerns regarding this authorization may be directed to me, through the information provided on the first page.

Parent/Legal Guardian Print Name:_____

Parent/Legal Guardian Signature:_____

Date:_____

Witness Print Name:_____

Witness Signature:_____

Date:_____