EMERGENCY MEDICAL TREATMENT PERMIT/LIMITED POWER OF ATTORNEY

(PLEASE TYPE OR PRINT)

Name(s) of child or children:

_____
Last First Middle Birthdate

_____
Last First Middle Birthdate

_____
Last First Middle Birthdate

_____
Last First Middle Birthdate

Name of person(s) giving consent:

_____
Last First Middle

_____
Last First Middle

I, the undersigned, do hereby grant _____ limited Power of Attorney, to act for me and to give the required consents and authorizations for the delivery of medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child(ren) listed above, for a period of time from,_____ and to do all other necessary things as I might or could do if personally present.

This limited Power of Attorney is given pursuant to the provisions of PA 1978, 642, Sec 405, of the Probate Code, and said power of attorney is not to exceed nine months.

_____
Signature of person qualified to consent Relationship to child/children

Address:

_____
_____

Witness OR Notary Public

_____
Date

(SEE BACK FOR PERSONAL/MEDICAL INFORMATION)

PERSONAL/MEDICAL INFORMATION

Date: _____

Telephone number and address where parents can be reached:

Home Phone: _____

Work Phone: Father _____
Days/Hours _____
Mother_____
Days/Hours _____

Address:_____
_____

Private Physician _____
Phone _____

Insurance Company: _____
Policy Number _____

Known allergies or significant medical history:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Last Tetanus immunization (list for each child)
_____
_____
_____
_____
_____

Other Comments:
_____
_____
_____
_____
_____