# BLOOMFIELD PEDIATRIC CARE
# UNEMANCIPATED MINOR POLICY

**This is a form that the Practice uses as an authorization to treat minor children in the absence of the parent or legal guardian.**

## Authorization for Medical Treatment of Your Children

***Are you planning a trip? Away for the day? Are your children in school?***

If your child needs emergency or non-emergency medical, dental, surgical care or hospital services, you, as a parent or legal guardian, must give permission.

***What about times when you cannot be reached for permission?***

In an emergency, your child may be treated without your consent if a physician determines that your child needs immediate medical care and further delay increases the risk to your child's life or health. In situations that are not emergencies, your child may need unexpected care. In these cases, contacting parents for permission can delay treatment and create unnecessary anxiety and discomfort for your child.

***How can you prepare for the unexpected care your children might need when you are away?***

- Make sure the person who is caring for your child knows how to reach you at all times.
- When you know you will be hard to reach, use the form below to give permission to other adults to authorize medical care for your child. They can then act for you and give permission for your child to be treated if unexpected care is needed.
- Fill out this form carefully. With it, you may appoint relatives, friends, teachers, neighbors or anyone you know over 18 years of age to authorize treatment in your absence. For further protection, have the form signed by an adult other than the person you tha appointed to authorize medical care for your child.
- After you complete the form, give it to the adults you have designated and explain its use. Make sure they know that they should take the form with them to the physician's or dentist's office, or to the hospital.

| NAME of MINOR(S) | BIRTHDATE | Allergies or Special Conditions | Health Insurance Plan/Policy # |
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I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

1) **Name**_____ Phone_____

Address_____ City_____ State_____ Zip_____

2) **Name**_____ Phone_____

Address_____ City_____ State_____ Zip_____

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

_____ through _____

Month Day Year Month Day Year

In no event shall this delegation of parental rights be effective for more than six (6) months.

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

Parent/Guardian _____ Parent/Guardian _____

*Signature* *Signature*

Address _____ Address _____

Date _____ Date _____

Witness: _____ Witness: _____

*Signature* *Signature*

**Appointed Representative of Parent/Guardian** _____ Date _____

*Signature*

**Appointed Representative of Parent/Guardian** _____ Date _____

*Signature*

This is a legal document. Take it with you and give it to the physician, dentist or hospital representative so that necessary treatment can be given to a child whose parents cannot be contacted for permission.

Medical Site Reviewers, 2004