Dartmouth Health **AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD**	MRN: NAME: Two identifiers needed DOB:

I, _____ (name of parent/legal guardian), residing at

_____ (parent/legal guardian's address)

acknowledge that I am the lawful parent/guardian of _____ (name of child)

_____ (date of birth of child) and that there are no court orders or other documents in effect that would prevent me from conferring the power of consent to another person.

I hereby authorize and appoint _____ (name of agent)

residing at _____ (agent's address) to consent to my child's medical examination and treatment. I give this consent voluntarily in order to make sure that my child receives adequate healthcare.

This authorization will remain in effect for a period not exceeding one year.

LIMITATIONS: Identify any limitations on the kinds of medical services for which authorization is given. If none, state "none".

_____

CONTACT: If the nature of the medical care is not routine, please try to contact me. If you are unable to contact me for any reason, you may rely on the proxy decision-maker for the consent.

Signed and dated this _____ day of _____.

_____

Print name of parent or legal guardian Relationship

_____

Signature of parent or legal guardian

_____

Witness print name Witness signature Date

_____

Witness print name Witness signature Date