Family Care Center
1305 E 19th Ave
Winfield, KS 67156-5201
620-221-9500

Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable

Patient Name:
Patient Date of Birth:

The undersigned parent(s) or guardian(s) of _____ , a minor, authorizes _____ to consent to treatment of _____including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not available in person, or immediately by telephone.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the physician to diagnose and treat the minor in the parent's/guardian's absence.

1. Person(s) to contact in an emergency:
   a._____ Phone:_____
   b._____ Phone:_____

2. Medical concerns or learning disabilities: _____

3. Known allergies: _____

4. Health Insurance Plan: [Invalid request] [Invalid request]

Parent(s) Name

Mother: _____ Father: _____

Daytime Phone: _____ Daytime Phone: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Signature of Parent/Guardian: _____

Date: _____

This consent shall remain in effect until written revocation is received by the physician/clinic.