Louisville Pediatric
SPECIALISTS

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

The undersigned parent or legal guardian of _____authorizes
(Print Name)
the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person or by telephone. It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

2. Medical Concerns:_____
3. Known allergies:_____

Name of Parent or Legal Guardian:_____
(Print Name)

Relationship to Child:_____

Contact Numbers: **Home**:_____**Cell**:_____**Work**:_____

Address:_____ City, State, Zip: _____

Signature:_____ Date: _____

This Consent is effective until withdrawn in writing by the child's parent or guardian.