NATHAN LITTAUER HOSPITAL

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR TEMPORARILY SEPARATED FROM HIS PARENTS

I/We, the undersigned, parent(s) of _____ who is/are a minor(s), do hereby authorize _____ _____ as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon, on the staff of or engaged by Nathan Littauer ;Hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

This authorization shall be effective during the period of _____ to _____, unless sooner revoked in writing delivered to said agent(s):

PARENT/GUARDIAN

_____
(SIGNATURE)

DATE: _____

ADDRESS: _____

TELEPHONE: _____

PARENT/GUARDIAN

_____
(SIGNATURE)

DATE: _____

ADDRESS: _____

TELEPHONE: _____

WITNESS

_____
(SIGNATURE)

DATE: _____

WITNESS

_____
(SIGNATURE)

DATE: _____

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR(S)

_____
NAME OF INSURANCE COMPANY OR GOVT. PROGRAM

_____
IDENTIFICATION OR CONTRACT NUMBER

FAMILY PHYSICIANS

_____
NAME & PHONE NUMBER

_____
NAME & PHONE NUMBER

DATE OF LAST TETANUS: MONTH _____ YEAR: _____

ALLERGIES: _____ ILLNESSES: _____

MEDICATIONS: _____ CHRONIC CONDITIONS: _____

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