Advance Consent to Treat Minors

Example 1:

I, __________________________, the parent or legal guardian of __________________________, authorize and consent to routine and emergency medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

________________________________________________________________________
Signature of parent/legal guardian Date

Example 2:

I, __________________________, the parent or legal guardian of __________________________, authorize and consent to medical treatment and procedures to be performed for him/her by a licensed physician when deemed necessary or advisable by the physician to safeguard my child’s immediate health and I cannot be contacted. I waive my right to informed consent to such treatment with the understanding that every attempt to contact me has been made.

________________________________________________________________________
Signature of parent/legal guardian Date

Example 3:

I, __________________________ (name of parent/legal guardian), hereby authorize __________________________ (name of practice) to provide such services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of those members of my immediate family who are minors. This authorization shall continue to be in full force and effect until revoked in writing by me.

________________________________________________________________________
Signature of parent/legal guardian Date
Example 4:

The undersigned hereby authorizes ________________________________ (name of practice) as our agent to give consent to surgical or medical treatment by any licensed physician or hospital in the state of Washington for _________________________________, my minor child, when such treatment is deemed necessary by such physician and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections or drugs and the performing of whatever procedures may be deemed necessary or advisable. Further, consent is granted to said physician to exercise his or her discretion in authorizing the disposal of any severed tissue or members.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child’s attending physician, in the exercise of his or her best judgment, may deem advisable.

This authorization shall remain effective unless revoked in writing by the undersigned.

____________________________________________  ________________
Signature of parent/legal guardian                  Date