

**Authorization for Medical Treatment of Minors**

If your child needs medical, dental, health or hospital services, you as a parent must give permission. IT IS THE LAW.

If however, a physician determines that a true medical emergency exists, a child may be treated without parental consent. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child’s life or health.

You can prepare for unexpected emergencies that may arise when you are not available by complete g the “Authorization for Medical Treatment of Minors” to appoint an adult to act on your behalf. This form will only be accepted when you can not be reached in an emergency; this form is not valid for consenting to major elective procedures.

This form is a legal document. With it you may appoint relatives, friends, teachers, clergy, neighbors or child care providers- anyone who is over 18 years of age- to be responsible for your children when you are away from them. If is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form carefully and completely. Have your signature witnessed by an adult different from the person you are making responsible for your children.

After you complete this form, give it to the adult(s) you have named to act on your behalf. If you child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person- physician, dentist, or hospital representatives.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Minors | Birthdates | Insurance Company | I.D. or Contact # |
|  | /  / |  |  |
|  | /  / |  |  |
|  | /  / |  |  |
|  | /  / |  |  |
|  | /  / |  |  |

I\We, being the parent(s) or legal guardian(s) of the above named minor(s) , do hereby appoint:

Campus & Community Children’s Center

280 Central Avenue

SUNY Fredonia

Fredonia, New York 14063

716-673-4662

To act on my\our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my\our absence:

|  |  |  |  |
| --- | --- | --- | --- |
| Date: | /  / | To Date: | Present |
|  | |  | |
| Parent\Guardian Signature | | Parent\Guardian Signature | |
|  | |  | |
| Address | | Address | |
| /  / | | /  / | |
| Date | | Date | |
|  | |  | |
| Witness Signature | | Date | |

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