RELEASE/PERMISSION FOR TREATMENT OF A MINOR

We, the parents of _____
(Name of child, children)

give _____
(Name of Temporary Care Giver)

permission to authorize medical treatments and/or life sustaining measures as deemed necessary to treat his/her/their condition(s) in our absence from
_____ to _____.
(Date) (Date)

_____ _____
Parent or Guardian Print Name Date

_____ _____
Parent or Guardian Sign Name Date

Child's Name _____ _____ _____

Date of birth: _____ _____ _____

Social Security # _____ _____ _____

Allergies _____ _____ _____

Immunizations _____ _____ _____

Medications _____ _____ _____

Primary Physician _____ _____ _____

Medical records for this child/these children are located at:
_____

_____

_____

Ins. Co_____ Ins #_____

Address: _____ Ins Name_____

_____ Employer_____

_____
Witness

HIM 05/18

TRI VALLEY
HEALTH SYSTEM