

If your child needs medical, dental, or hospital services, you as parent must give permission. It's the law.

What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parent consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your child might need when you are away from home. To do this, make sure babysitters know how to reach you at

all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

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

Fill out this form carefully. 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 in your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person - physician, dentist or hospital representative.

# Authorization for medical treatment of minors

NAMES OF MINORS	BIRTHDATES	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

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

NAME	ADDRESS	PHONE
NYSED OBE	89 Washington Ave, Albany, NY	518-474-8775

To act in 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, from:

MONTH, DAY, YEAR	THROUGH	MONTH, DAY, YEAR

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

PARENT/GUARDIAN SIGNATURE		PARENT/GUARDIAN SIGNATURE	
ADDRESS:	DATE	ADDRESS:	DATE
WITNESS SIGNATURE		WITNESS SIGNATURE	
ADDRESS:	DATE	ADDRESS:	DATE

## HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S)

INSURANCE COMPANY OR GOVERNMENT PROGRAM	I.D. OR CONTRACT NUMBER
FAMILY PHYSICIANS:	
NAME AND PHONE NUMBER	NAME AND PHONE NUMBER