

CONSENT/AUTHORIZATION FOR TREATMENT OF MINORS

You are about to leave for a well-deserved vacation. Your best friends/parents have agreed to watch your children while you are gone. Everything is packed, the kids are excited to be staying with your friends/parents and you've left the emergency numbers. But there is one important detail that you may have forgotten....

During your absence, your child may suffer an illness or injury that requires medical attention. To ensure that your child will get that attention as easily as possible, you should complete an "Authorization for Consent to Medical Treatment for Minors" form before you leave. This form gives the child's designated care taker or non-parent family member the right to authorize treatment if the need arises. In an emergency situation, your child would automatically be treated. Of course, every reasonable effort would be made to contact you as soon as possible, but it may prove to be difficult if you are not near a telephone or do not have cell phone reception.

As a general rule, minors cannot consent to treatment. Therefore, except in special situations, e.g., emergency treatment or emancipation, a physician must obtain the consent of the parent(s) or legal guardian to treat a minor. In the case of a medical emergency, when a child requires immediate treatment in order to save his or her life or to prevent injury to health, treatment may proceed without parental consent.

Please complete this form. That way we will know that you have authorized the designated person to make medical decisions in your absence.

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINORS

In the event the undersigned parent/guardian of _____, cannot be contacted through reasonable efforts, they do hereby empower and grant to:

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| NAME | ADDRESS | PHONE NUMBER |
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the right to consent permission of any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or Hospital Care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of North Carolina, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

This authorization shall be valid until I provide revocation to Chapel Hill Children's Clinic in writing. I do hereby indemnify and hold harmless the physician, hospital, and other persons who act in reliance upon this authorization.

Executed this _____ day of _____ 20____.

PARENT/GUARDIAN

When there is more than one legal guardian/person with parental rights, authorization for routine access/permission to make medical decisions, as well as portal access requires the signatures of both/all. In the event of an emergency, when both signatures are not present, Chapel Hill Children's Clinic will make every reasonable effort to receive authorization.

PARENT/GUARDIAN CONTACT INFORMATION:

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|------|--------------|------------------------|
| NAME | PHONE NUMBER | ALTERNATE PHONE NUMBER |
|------|--------------|------------------------|

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| NAME | PHONE NUMBER | ALTERNATE PHONE NUMBER |
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