OSF Healthcare System

PERMISSION FOR TREATMENT OF MINOR

Parents/legal guardian (names) ____

____

Phone number where I can be reached 1 ___________________2___________________

We/I give (full name(s) ____

____

permission to consent for care of the following child/children:

Minor ____________________________________ Date of Birth ____________________

Minor ____________________________________ Date of Birth ____________________

Minor ____________________________________ Date of Birth ____________________

Minor ____________________________________ Date of Birth ____________________

Minor ____________________________________ Date of Birth ____________________

Permission starts on (date) _______________________for one year unless written notice is received removing the permission.

The above-named individual(s) shall have permission to seek appropriate medical treatment or attention on behalf of the child/children as may be required by the circumstances, including but not limited to medical doctor and /or hospital visits.

Please send copy of insurance card front and back with the person given permission.

DATED: ____

SIGNED: ____

(Parents/Legal Guardian)

WITNESSED: ____