

Name of Minor Child: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give \_\_\_\_\_ (name of guardian over 18) the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that this authorization relieve the physician, dentist, or other person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that the above named guardian shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by the above named guardian. I understand that this form is in effect from the date signed and that it is my responsibility to inform MWMA, Inc. of any changes to this form.

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Guardian over 18)

\_\_\_\_\_  
(Date)

Parent Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Minor's Last Tetanus Shot (if known):

List Current Medications:

\_\_\_\_\_

\_\_\_\_\_

Known Allergies:

\_\_\_\_\_

Medical history or other important facts that should be known:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_