Grand Traverse Internal and Family Medicine

5015 North Royal Drive
TRAVERSE CITY, MI 49684
PH# 231-935-0850 FAX# 231-935-0869

Authorization & Consent for Treatment

NAME OF CHILD:

Last First Middle Date of Birth

The undersigned does hereby grant to the individuals listed below. (Name two adult individuals who will be responsible for the care of your child or children in your absence).

Name of responsible adult Phone Number

Or in the event this individual is not available, I hereby grant the following individuals:

Grand Traverse Internal and Family Medicine, P.C.

The limited Power of Attorney to act for me and to give the required consents and authorizations for the delivery of medical care, diagnosis and treatment, including surgical intervention, if necessary, on behalf of my minor children listed above for a period of time during my absence from _____to _____ (not to exceed six months and to do all other necessary things as I might or could do if personally present.)

Telephone number and address where parents can be reached: _____

Insurance Company Information: (Please include Name, Phone Number, Address, Subscriber ID# and Group Number)

_____

Known Allergies/Significant Medical History:

_____

Last Tetanus Immunization: _____

Printed name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____