RAINBOW PEDIATRIC P.C.

Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable

The undersigned parent or legal guardian of (Child's Name)__________________________________ authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to (Phone)________________________. It is understood that this consent is give in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name:__________________________Relationship to Child:________________Phone:_______________

   Name:__________________________Relationship to Child:________________Phone:_______________

   Name:__________________________Relationship to Child:________________Phone:_______________

2. Medical concerns: ____
3. Known allergies: ____

Name of Parent or Legal Guardian: _________________________________Relationship to Child:________________

Contact Number(s): ____

Address: ___________________________________ City, State, Zip_______________________________________

Signature: ____ Date: ______________________________

This Consent is effective until withdrawn in writing by the child's parent or guardian.

1636 Main Street, Humboldt, TN 38343

Phone: 731-784-7833 Fax: 731-784-7856

Revised 4/11/14