AUTHORIZATION FOR MEDICAL TREATMENT IN THE ABSENCE OF LEGAL GUARDIAN

Patient(s) Name(s):_____DOB:_____

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I give to:_____ my permission to authorize any and all medical treatment(s) for my child named above.

In my absence, I give permission to Rainbow Kids Clinic, and its staff to examine and provide emergency treatment to my child, _____. In addition, the physicians/clinic have my permission to refer my child's emergent care and treatment to the appropriate service physician/hospital/lab/urgent care or medical facility to provide optimal care for the treatment of illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care.

This authorization becomes effective on _____and ends on _____
DATE **DATE/NEVER**

_____

Parent/Legal guardian Signature **Relationship to Patient** **Date**