SWEDISH
MEDICAL GROUP

Authorization to Consent for Treatment of a Minor When Accompanied by a Non-Parent/Guardian

I/We hereby authorize (name of individual authorized to consent on behalf of parent/guardian):

_____ as our agent to give consent to medical, or surgical treatment by any licensed physician or hospital in the State of Washington for our child:

_____ when such treatment is deemed necessary by a physician or hospital personnel and I/we am/are unable to accompany my child and cannot be contacted within a reasonable period of time.

Such consent may include, but is not limited to: clinic visits; medical treatment; tests; imaging studies, including x-rays; transfusions; injections; medications; and the performing of whatever operations may be deemed necessary or advisable.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide the agent identified in this authorization the authority to provide consent to such medical care s/he may deem advisable in the exercise of his/her best judgment.

I understand that I am responsible for payment of all charges related to the care my child receives for examination or treatment under this authorization even though my child is not accompanied by me.

This authorization shall remain effective until revoked in writing by the undersigned.

PLEASE COMPLETE:

Date of last tetanus immunization: _____

Does your child have any chronic diseases or drug allergies that might interfere with medical or surgical treatment? Yes ☐ No ☐

If yes, please describe:_____

_____

_____

_____
Printed Name Parent/Guardian

_____
Printed Name Parent/Guardian

_____
Signature Date

_____
Signature Date

Witnessed By: (office staff member)

_____
Printed Name

_____
Signature Date

Facility where signed: _____