**Pediatric Associates of Franklin**

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

# Patient Name DOB

I give permission to the physicians, providers, and nurses of Pediatric Associates of Franklin to treat my child in my absence. I authorize any medical treatment that may be necessary in an emergency and in my absence for the well-being of the above-mentioned minor.

It is understood that this consent is given before 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:

1. Medical concerns:
2. Known allergies:
3. Medications

Name of Parent or Legal Guardian\*: Relationship to Child:

(Print Name)

Contact Number(s):

Address: City, State, Zip:

# Signature: Date**:**

\*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child’s parent or guardian or until the child turns 18 years of age.