



SAINT LUKE'S HEALTH SYSTEM

saintlukeshealthsystem.org

Temporary authorization to consent to treat a child

Date _____

I (we) _____
Name(s) and address(es) of parent(s)

designate to _____
Name and address of designee

the power to consent in our absence to medical care for our child(ren)

Name(s) and age(s) of child(ren) _____

Parent(s)' phone number(s) _____

Child(ren)'s physician _____

Physician's address and phone number _____

Medical insurance company _____

Policy # _____

Dates of expected absence from _____ to _____

Child(ren)'s medical history

Chronic conditions _____

Medications that need to be taken on a regular basis _____

Allergies _____

Dietary or other restrictions _____

Parent(s) signature(s) _____