Temporary Authorization of Consent to Treat a Child

I (we)____
Name(s) and address(es) of parents

designate to ____
Name and address of designee

the power to consent in our absence from __________ to ________ to medical care for our child(ren) [List Name(s) and age(s) of child(ren)}

_____________________________________ ___________________________________

_____________________________________ ___________________________________

Parent(s)' phone number: ____

Child(ren)'s physician(s): ____

Physician's address and phone number: ______________________________________

____

Health Insurance company: ____
Policy #: _______________________________Group # ___________________________
Dates of expected absence from __________________ to __________________

CHILD(REN)'S MEDICAL HISTORY

Chronic conditions| Allergies | Dietary Restrictions_____________________________

Medications that need to be given on a regular basis:

_____________________ ____
Child's Name Medication name, dosage, frequency

_____________________ ____
Child's Name Medication name, dosage, frequency

_____________________ ____
Child's Name Medication name, dosage, frequency

_______________________________________ __________________
Signature **Date**

State of Georgia
County of _________________
This instrument was acknowledged before me this _____day of _________ (month), __________ (year), by_________________________ (name of signer).

______ Personally Known
______ Produced Identification
Type and # of ID_______________________

(Seal)

____
(Signature Notary)

____
Name of Notary Typed, Stamped or Printed) Notary Public, State of Georgia