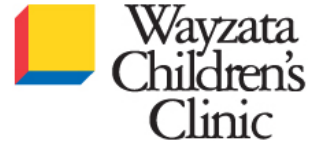


TEMPORARY CONSENT TO TREAT

Please list individuals other than legal guardians who are granted temporary authorization to consent to recommended medical care for your child.



1) PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth
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2) EFFECTIVE DATE: _____

3) PARENT(S) NAME(S): _____

4) PHONE NUMBER(S) WHERE PARENT(S) CAN BE REACHED: _____

5) PERSON(S) CARING FOR MY CHILD:

Name(s)	Relationship	Name(s)	Relationship

6) MY CHILD IS USUALLY SEEN AT THE FOLLOWING OFFICE:

Wayzata Children's Clinic

- 111 Hundertmark Road, Suite 420 • Chaska, MN 55318-1459 • 952-448-3847 • Fax: 952-448-5083
- 916 St. Peter Avenue, Suite 120 • Delano, MN 55328-2813 • 763-230-2780 • Fax: 763-972-2230
- 14001 Ridgedale Drive, Suite 100 • Minnetonka, MN 55305-1781 • 952-473-0211 • Fax: 952-473-7908
- 4695 Shoreline Drive, Suite A • Spring Park, MN 55384-9715 • 952-495-8910 • Fax: 952-471-2585

7) INSURANCE AND MEDICAL INFORMATION:

Insurance Company: _____

Group/Policy #: _____ ID#: _____

Effective Date: _____

Child's Medical History: _____

Chronic conditions: _____

Medications that child takes on a regular basis: _____

Allergies: _____

Dietary or other restrictions: _____

8) AUTHORIZATION:

I/We give permission for the person(s) listed above to make medical decisions for **my/our** child in **my/our** absence. I/We can be reached at the number(s) above in case of an emergency.

I understand that this consent will last for one year or for the date range indicated above. I understand that I can revoke this consent at any time in writing. Revocation will not apply to actions already taken by Wayzata Children's Clinic.

Signature of Parent or Legal Guardian	Printed Name	Relationship	Date
Signature of Parent or Legal Guardian	Printed Name	Relationship	Date