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.

Wayzata Children's Clinic

1) PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth

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

_____

Name(s) Relationship Name(s) Relationship

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

- ❑ 111 Hundertmark Rd #420 • Chaska, MN 55318-1459 • 952-448-3847 • Fax: 952-448-5083
- ❑ 916 St. Peter Ave N #120 • Delano, MN 55328-2813 • 763-230-2780 • Fax: 763-972-2230
- ❑ 14001 Ridgedale Dr #100 • Minnetonka, MN 55305-1781 • 952-473-0211 • Fax: 952-473-7908
- ❑ 9325 Upland Ln N #111 • Maple Grove, MN 5369-4437 • 763-324-8000 • Fax: 952-473-7908
- ❑ 4695 Shoreline Dr Ste 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