ENVISION
MEDICAL GROUP

WHEN YOUR CHILD NEEDS TO SEE THE DOCTOR, BUT YOU CANNOT BE THERE

Anytime you cannot come to the doctor's office with your child, be sure you send the child to the doctor's office with an adult (18 years and older) and give that adult written permission to get treatment for your child.

By law a doctor cannot treat a child, except in a life or death situation, unless the parent or guardian gives consent. Your child's care, or immunizations, could be needlessly delayed because you cannot get to the office. Therefore, if you cannot come to the office with your child, make sure that the adult that brings your child to the office can make medical decisions for your child.

The doctor might want to run a blood test and your child might need a shot. If you are not there, and the adult who brings your child does not have your permission to allow the doctor to run the test or get the shot, your child's treatment will be delayed. You can avoid this by making sure that the adult caregiver has the proper written consent to make medical decisions for your child. You may revoke this designation at any time by signing and dating the revocation of your copy of this form.

Outpatient Treatment Permit/Authorization:

_____ _____

Last Name Middle Initial First Name Date of Birth

The undersigned does hereby grant to the individuals listed below (name of two adult individuals who will be responsible for the care of your child or children in your absence) the limited Power of Attorney to act for me and to give the required consents and authorizations for delivery of medical care, diagnosis, and treatment, if necessary from _____ (today's date) and to do all other necessary things as I might or could do if personally present, to include, but not limited to:

- Health Maintenance visits (routine and immunizations)
- Acute illness (outpatient care and treatment)
- Routine office procedures (x-rays, blood test, etc.)

1._____ _____

Name of Responsible Adult Phone #

2._____ _____

Name of Responsible Adult Phone #

_____ _____

Signature of Parent of Legal Guardian Relationship to Child/Children

_____

Address City State Zip Code Phone #

_____ _____

Witness of Employee of Envision Medical Group Date

Revocation Section:

I hereby revoke this designation of personal representative:

_____ _____

Signature Date