

AUTHORIZATION FOR EMERGENCY CARE OF MINOR CHILD

A. Authorization by Parent(s) To Care For Children. I, _____ and _____ (collectively and individually "Parent"), residing at _____, make, and declare this my medical authorization, directive and instruction (my "Authorization") concerning the care of _____ (individually and collectively "Child").

B. Agent Shall be Deemed In Loco Parentis to Child. It is my express intent, and I hereby authorize, the Agent named herein, to act as, and be treated by all medical providers as acting, *in loco parentis* for my Child.

C. Agent to Authorize Medical Care for Child. In the event that I am not Available in the event of a medical need, I authorize and direct that any doctor, hospital, emergency room facility, ambulance or other medical care provider ("Medical Care Provider"), rely on the instructions of the first person in the following list who is able and willing and Available to act ("Agent"), in caring for any of the Child in a medical emergency, or until I can reasonably be contacted. If any person on the list below is not Available the medical care provider should contact the next person. The term "Available" shall be determined in the reasonable discretion of the Medical Care Provider.

Name	Relationship	Home Address	Telephone Numbers
_____	_____	_____ _____ _____	Work: _____ Home: _____ Vacation: _____ Cellular: _____
_____	_____	_____ _____ _____	Work: _____ Home: _____ Vacation: _____ Cellular: _____
_____	_____	_____ _____ _____	Work: _____ Home: _____ Vacation: _____ Cellular: _____
_____	_____	_____ _____ _____	Work: _____ Home: _____ Vacation: _____ Cellular: _____

D. Insurance Coverage.

Insurance Carrier Name	_____
Name of Insured	_____
Policy Number	_____

E. Guardian and Conservator. To the extent that I am permitted by law to do so, and subject to the terms of my will, I hereby nominate the person or persons indicated in the above chart, in the order so named, to serve as my child's temporary guardian of the person and temporary medical guardian, conservator, or in any similar representative capacity. Such request governs guardianship over the person(s) not property. If I am not permitted by law to so nominate, then I request that any court that may be involved in the appointment of a guardian, special medical guardian, conservator or similar representative for me, give the greatest weight to this request. In the event of my demise, the terms of my will shall govern.

F. Agents Authorized to Access Confidential Medical Information.

1. I expressly authorize the release of any medical information concerning my Child to my Agent, or any recipient designated by my Agent, including but not limited to private health information ("PHI").

2. I authorize my Agent to request, obtain, receive, and inspect any and all information bearing upon my Child's health and relevant to any determinations to be made respecting any health care decision (including, but not limited to, all medical treatments and procedures), to sign whatever authorizations for release of information which may be required by providers or others, and to waive any rights I may have for breach of confidentiality for the release of such information to my Agent. I intend for my Agent to be treated as I would with regard to the use and dissemination of my Child's individually identifiable health information and medical records. This authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 132d and 45 CFR 160-164. I specifically authorize, on behalf of my Child, any physician, dentist, health care professional, medical provider, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc., or any other health care organization that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to my Agent all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition.

G. Powers and Rights of Agents.

1. To make all necessary arrangements for my Child at any hospital, emergency room, or other health care facility, or similar establishment, including the transfer and removal of my Child from one such facility to another, and any decision reasonably necessary to assure that all my Child's essential needs are provided for at such a facility.

2. To give or withhold consent or informed consent to any medical procedures, test or treatment, including surgery, hospitalization, convalescent care, home care or other treatment which I, my Child, or another person may have arranged for my Child. To summon paramedics or other emergency medical personnel and seek emergency treatment for my Child. Such may include by way of example and not limitation routine health care, administration of prescribed medication, ordering of routine tests (including but not limited to x-rays), arranging transportation

to and from such medical care providers, and matters incident and related thereto.

3. The Agent shall be entitled to sign, execute, deliver and acknowledge any contract or other document that may be necessary, desirable, convenient or proper in order to exercise any of the powers described in this Authorization and to incur reasonable costs in the carrying out of this Authorization.

4. The Agent, however, shall not be permitted to take the following actions or make the following decisions ("Exclusions") [If none listed no exclusions shall apply]:

H. No Time Limit. I have considered the possibility of limiting the effectiveness of this instrument to a fixed period of time from the date hereof and have decided that it shall remain in full force and effect until revoked.

I. Authorization and Direction Binding. I expect my family, physicians and all those concerned with the care of my Child to regard themselves as legally (whether or not required by the law at the time of the execution, or the place of implementation, of this Authorization) and morally bound to act in accordance with these directions, and in so doing to be free from any liability and responsibility for having followed my wishes stated herein.

J. Third Parties. Third parties, including but not limited to medical professionals, insurance companies, hospitals, convalescent facilities, or the like, may rely upon the representations of an Agent as to all matters relating to any power granted to an Agent acting in the capacity as the Agent for my Child.

K. Construction. This Agreement shall be governed under the laws of the State of _____. This Agreement may be executed in one or more counterparts. Should any provision contained in this Authorization be unenforceable, such unenforceability shall not affect the enforceability of the remainder of this Authorization. The use of male, female, singular, or plural, shall be interpreted as the usage requires.

Acknowledgement of Parent(s) and Affidavits of Witnesses:

I, _____ and _____, being first duly sworn, do hereby declare that, I am the parent and legal guardian of the Child named in this Authorization, that I have executed this Authorization instrument willingly, as my free and voluntary act for the purposes herein expressed, that at the time of said execution I am Eighteen (18) years of age or older, of sound mind and under no constraint or undue influence.

Name: _____

Name: _____

State of _____)
) ss.:
County of _____)

On this _____, 20____ before me personally came _____, a Parent, to me known and known to me to be the individual described in and who executed the foregoing Authorization in my presence. The Parent duly acknowledged, subscribed and swore before me that such person understood the meaning of the Authorization and executed the same before me.

Notary Public

State of _____)
) ss.:
County of _____)

On this _____, 20____ before me personally came _____, a Parent, to me known and known to me to be the individual described in and who executed the foregoing Authorization in my presence. The Parent duly acknowledged, subscribed and swore before me that such person understood the meaning of the Authorization and executed the same before me.

Notary Public



Medical History and Related Information

Child Name	_____	_____	_____	_____	_____
Blood Type					
Allergies					
Existing Medical Conditions					
Medications Taken					
Child's Past Medical History					
Smoke/Drink/Drug Use					
Family Medical History					
Religious Restrictions on Care					
Child's Social History					
Other Comments					
Tips on How to Comfort Child (favorite toys; etc.)					