MCH
MORRIS COUNTY HOSPITAL

Council Grove, KS 66846
600 N Washington
(620) 767-6811
Fax (620) 767-5611

RE: Authorization for Medical Care for minors

Did you know? - Parents and Legal Guardians are the only people who may give consent for medical treatment of a minor.

Parents and legal guardians may, however, appoint (in writing) adult caregivers to consent to treatment of minor children. The attached form may be used for this purpose.

As the parent or legal guardian of minor child/children, you may appoint another to give consent for treatment by filling out and signing the attached form.

Please fill out a separate form for each child.

This appointment cannot cover a time period longer than one year.

Give the completed form to the person you have appointed to give consent. They should take the completed and signed form with them if they take your children to the doctor or hospital for treatment while caring for them.

You may copy this blank form for future use or visit the Morris County Hospital web site, http://www.mrcohosp.com/.

APPOINTMENT OF AGENT
(Authorization for Medical Care)

I/we, the undersigned, hereby appoint _____ of lawful age, as my/our agent and representative for the purpose of authorizing and consenting to hospital, medical, or surgical care and treatment of my/our child/ward _____ _____, for any illness or injury that may occur while he/she is in the care or custody of said agent and I/we the undersigned am/are not present to give such consent. This authorization is not intended to allow the named agent to have access to medical information regarding said child/ward or to control the distribution of medical information except as is necessary for furtherance of medical care.

INFORMATION FOR MEDICAL CARE:

Legal Name of child/ward _____ DOB:_____
Address:_____

Chronic illnesses or Allergies:_____
_____

Current Medications:
Drug_____Dosage_____ Physician_____
Drug_____Dosage_____ Physician _____
Drug_____Dosage_____ Physician_____

Date of last Tetanus Shot:_____
Child=s/ward=s Physician_____Phone #_____

Health Insurance Company: _____Group # _____
Person Responsible for Payment_____ Phone# _____
Employer of Responsible Party:_____

INFORMATION ABOUT ME:

I am the child=s parent -- legal guardian -- other_____. (Circle one)
Home address:_____
Phone #: _____

☐ This consent is to be in full force for one year.

☐ This consent is to be in full force and effective from this date through and including _____ (Cannot be longer than one year.)

This consent can only be revoked in writing by the undersigned.

Signature_____ Date _____

Witness_____ Date _____