DFW Pediatric Neurology

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AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINORS AND THOSE DEEMED INCOMPETENT

In the event the undersigned parent/guardian of _____, cannot be present, or cannot be contacted through reasonable efforts, I do hereby empower and grant to:

_____

NAME ADDRESS PHONE NUMBER

The right to consent permission of any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of Texas, when the need for such treatment is immediate, and when the efforts to contact me (us) are unsuccessful. I also grant them permission to act as the legal guardian when unable to be present during routine and scheduled medical appointments. I do hereby indemnify and hold harmless the physician, hospital, and others persons who act in reliance upon this authorization.

Executed this_____day of _____20_____

_____

Parent/Legal Guardian