Tennessee Family Medicine PLLC

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

Patient Name _____ DOB _____

I give permission to the physicians, providers and nurses of Tennessee Family Medicine to treat my child in my absence. I authorize any medical treatment which may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows

the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____
4. Medications _____

Name of Parent or Legal Guardian*: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent or guardian or until child turns 18 years of age.