LOUISVILLE PEDIATRIC SPECIALISTS, PSC
6801 Dixie Hwy., Ste. 127
Louisville, KY 40258
Phone: 502 935-5633 Fax: 935-5706

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

The undersigned parent or legal guardian of _____authorizes
(Print Name)
the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person or by telephone. 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:_____

   Name:_____Relationship to child:_____Phone:_____

2. Medical Concerns:_____
3. Known allergies:_____

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

Contact Numbers:**Home**:_____**Cell**:_____**Work**:_____

Address:_____City, State, Zip:_____

Signature:_____Date:_____

This Consent is effective until withdrawn in writing by the child's parent or guardian.