MUNSON HEALTHCARE

0174

TEMPORARY DELEGATION OF PARENTAL RIGHTS AND CONSENT TO MEDICAL TREATMENT OF A MINOR OR DEPENDENT ADULT

Anytime you are going to be separated from your children or those under your care, be sure to leave written permission for emergency treatment on file with Munson Healthcare. By law, hospital emergency personnel cannot provide treatment in the event he or she becomes ill or injured, except in life or death situations, without parental/guardian authorization. Care could be needlessly delayed while the hospital attempts to contact you. With the proper consent on file, you ensure immediate care, should it be necessary in your absence.

Kalkaska Memorial Health Center
Mackinac Straits Health System
Munson Healthcare Cadillac Hospital
Munson Healthcare Charlevoix Hospital
Munson Healthcare Grayling Hospital
Munson Healthcare Manistee Hospital
Munson Healthcare Otsego Memorial Hospital
Munson Medical Center
Munson Urgent Care
Paul Oliver Memorial Hospital
Other: _____

Instructions:

1. **Complete both pages of this form and deliver to any Munson Healthcare facility so it can be scanned into the electronic health record.**
2. **Keep a copy and give a copy to the adult(s) you have designated, explain its use and instruct them to bring this form with them if they are seeking treatment for the minor(s) or dependent adult(s) under their care.**

TELEPHONE NUMBER AND ADDRESS WHERE PARENT OR GUARDIAN CAN BE REACHED:

Phone (_____) _____ Phone (_____) _____

Address: _____

HMO/INSURANCE/PRIMARY CARE PROVIDER INFORMATION:

Private physician: _____ Phone: (_____) _____

Insurance: _____
Company Policy Number

MINOR PATIENT OR DEPENDENT ADULT MEDICAL INFORMATION: (list each child/dependant adult)

Name(s) of Minor or Dependent Adult	Known Allergies/Drug Sensitivities	Known Medical Conditions	Last Tetanus Immunization

PATIENT ID LABEL

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PERMISSION FOR TREATMENT

Name(s) of child/children/dependent adult(s): (please type or print legibly)

Last	First	Middle	Birthdate

Parent/legal guardian giving consent (PRINT) _____ **Last** **First** **Middle**

I am the parent or legal guardian of the above-named minor child/children/dependent adult(s). I appoint the following individuals Limited Power of Attorney to act for me and to give the required consents and authorization for the delivery of medical care, diagnoses and treatment, including surgical intervention, if necessary, on behalf of my minor child/children or dependent adult(s):

NAME OF RESPONSIBLE ADULT	PHONE NUMBER	NAME OF RESPONSIBLE ADULT	PHONE NUMBER

I authorize the above permission for a period of time during my absence from _____ to _____ (not to exceed 6 months) and to do all other necessary things as I might or could do if personally present. I understand this delegation includes receiving health information about the minor necessary to make health decisions.

This limited Power of Attorney is given pursuant to the provisions of PA 386 of 1998, Sec 700.5103 of the Estates and Protected Individuals Code and said Power of Attorney is not to exceed six months(or longer, for up to 30 days following return from overseas deployment of active military personnel). This form does not delegate power to consent to marriage or adoption.

INSTRUCTIONS: At least one parent or legal guardian must sign this form AND obtain signatures for either options 1 or 2

PARENT OR GUARDIAN	DATE	TIME

Option 1: Two witness signatures are required. The witnesses should NOT be employed by Munson Healthcare (per policy 043.002.), related by blood or marriage, or listed above as being delegated consent.

WITNESS	DATE

OR* Option 2:** ***On this day, before me, the undersigned Notary Public,the parent(s) or guardian(s) herein named personally appeared and freely executed this document. He/she/they are personally known to me or has/have provided satisfactory evidence of their identity.

Notary Public

SIGNATURE	DATE

PATIENT ID LABEL