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.

1. **Complete this form and send/bring to your emergency department, or hospital medical records department.**

2. **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.**

☐ **Kalkaska Memorial Health Center**
419 S. Coral St.
Kalkaska, MI 49646
231-258-7500

☐ **Munson Healthcare Charlevoix Hospital**
14700 Lake Shore Dr.
Charlevoix, MI 49720
231-547-4024

☐ **Munson Healthcare Manistee Hospital**
1465 E. Parkdale Ave.
Manistee, MI 49660
231-398-1000

☐ **Munson Urgent Care**
550 Munson Ave.
Traverse City, MI 49686
231-935-8686

☐ **Munson Healthcare Cadillac Hospital**
400 Hobart St.
Cadillac, MI 49601
231-876-7200

☐ **Munson Healthcare Grayling Hospital**
1100 E. Michigan Ave.
Grayling, MI 49738
989-348-5461

☐ **Munson Medical Center**
1105 Sixth St.
Traverse City, MI 49684
231-935-5000 or
1-800-847-8474

☐ **Paul Oliver Memorial Hospital**
224 Park Ave.
Frankfort, MI 49635
231-352-2200

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

Phone (_____) _____ Address: _____

MINOR PATIENT OR DEPENDENT ADULT INFORMATION:

Name of minor/dependent adult: _____ Date of birth: _____

Known allergies/drug sensitivities: _____

_____

Known medical conditions: _____

_____

Last tetanus immunization (list for each child/adult): _____

_____

HMO/INSURANCE/PRIMARY CARE PROVIDER INFORMATION:

Private physician: _____ Phone: (_____) _____

Insurance: _____
Company Number

PATIENT ID LABEL

ORIGINAL: TO BE DELIVERED TO THE APPROPRIATE HEALTHCARE FACILITY WHERE THE MINOR(S)/DEPENDENT(S) ADULT WILL BE TREATED

COPY: KEEP A COPY FOR YOURSELF AND PROVIDE A COPY TO YOUR DESIGNATED CARETAKER WHILE YOU ARE AWAY

MUNSON HEALTHCARE

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

-COMPLETE AND FORWARD TO YOUR LOCAL EMERGENCY ROOM OR HOSPITAL MEDICAL RECORDS DEPARTMENT-

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 _____

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 _____

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 _____

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