Eastern Plumas Health Care
"People Helping People"

Consent to Treat

(For **NON-PARENT** caregivers of minor children when a parent is not present)

_____ _____
Child's name Date of Birth

When I, the undersigned parent or legal guardian of the child listed above, am not present, I

authorize: _____ who is _____ to the child and a
Name of adult who is the **NON-PARENT** whom you are authorizing to give consent to treat (grandparent, aunt, babysitter, etc)

caregiver of this child, to consent to any ancillary services, anesthetic, medical or dental diagnosis, immunization, injections or treatment; and/or hospital care to be provided to said child, when such services are recommended and supervised by Eastern Plumas Health Care.

This consent is given pursuant to the provisions of Family Code Section 6910

I understand that, despite this consent, Eastern Plumas Health Care, in its sole discretion, **may decide not to act on this consent**, and instead require my presence during my child's treatment or care.

I also understand that **I am financially responsible for any co-pays and charges** not covered by my insurance which are incurred as a result of this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains in effect until my child is

__ 18 years old or __ until the ____ of _____, 20___.

_____ _____
Parent or legal guardians name Parent or legal Guardians signature

_____
Date

Parent / guardian's
Home address: _____ Phone: _____
Parent / guardian's
Employment: _____ Phone: _____

Other phone number(s) at which parent or guardian can be reached: _____

Childs known allergies: _____

Other significant health problems: _____

Date of child's most recent tetanus shot: _____

Medications currently being given to child: _____

I agree to see to, and may consent to, the above-named child's medical/dental care, as provided on this form.

_____ _____ _____
NON-PARENT caregiver's signature Date **NON-PARENT** caregivers address and phone