Consent for Emergency Treatment of Minors in Absence of Parent(s) or Legal Guardians

for children attending: CORNER OF THE SKY

512 W. Buffalo Street

Ithaca NY, 14850. Phone (607) 272-4670

Full Name of Minor _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

I, the undersigned, am one of the legal guardians of the minor named above. I may be unavailable to personally authorize medical, dental, surgical care and hospitalization for said minor because said minor attends child day care at CORNER OF THE SKY.

I hereby give my consent and authorization for any emergency or non-emergency diagnostic procedure, medical, dental, surgical care and hospitalization that any health care provider so determined as advisable, in the best judgment of said health care provider including, but not limited to, any physician, dentist or hospital personnel providing health care to the minor.

In my absence I would like the health care provider to discuss the matter with the persons designated below. I authorize those persons, insofar as the law of New York State permits me to do so, to enter in to the decision, to convey to the provider my consent and to consent to said treatment.

I hereby authorize the health care provider to discuss in full with those persons designated any medical information that is required to help the input of the persons so designated.

I hereby hold harmless any physician, dentist hospital or hospital personnel, or other health care provider rendering such care to the minor from any liability resulting from the failure to obtain further consent from me as guardian of the minor and from any other person. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

I have put important medical facts, if any, below. The medical facts are intended to help a doctor, medical personnel, or other health care provider in deciding what treatment is to be given but is in no way intended to restrict the authorization and consent hereby given.

I hereby appoint one person from the staff members at Corner of the Sky, to be chosen at the discretion of the person in charge at Corner of the Sky at the time of such emergency, to participate in the health care decision making concerning said minor.

The period of time over which this authorization exists is as follows: During the hours they are in attendance at said Child Care beginning on_____ and ending on their last day of attendance.

It is intended that this document shall be presented to the physician, dentist, or appropriate hospital or medical representative at such time that the medical, dental, surgical care or hospitalization is authorized. It is intended that this authorization relieve the physician, dentist, or any health care provider or any hospital or institution in which such care is given from any liability resulting from the failure of me the guardian, or any other person, from signing a consent or authorization to render such care. It is the intent that the person or persons appointed herein shall be able to act in my stead in making decisions.

Signature of Guardian _____ Print Name_____ Date _____

Address _____ Zip _____ Phone #_____ Work _____

Other Legal Guardian _____ Phone # _____ Work _____

Medications:

Medical History and Other Pertinent Facts:

Child's Usual Doctor _____ Phone # _____