Regional Medical Center
709 West Main Street, PO Box 359
Manchester, IA 52057-0359
Phone: 563-927-7433 Fax: 563-927-7927

Minor Treatment Authorization

Regional Family Health
709 West Main Street, PO Box 359
Manchester, IA 52057-0359
Phone: 563-927-7777 Fax: 563-927-7988

This form grants authority to a designated adult to provide and arrange for medical care for a minor, where the minor is not accompanied by parents or legal guardians.

Please PRINT (except signatures) and provide complete information in each section.

Patient Name: _____

Date of Birth: _____ Gender: _____

Patient Address: _____

I, the undersigned, hereby grant the following designated adult(s) permission to:

☐ Obtain medical treatment and procedures for this child as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate healthcare providers, including but not limited to x-rays, blood transfusions, anesthetic, medication or other procedures necessary for diagnosis or treatment of my child.

☐ Obtain routine medical treatment from appropriate healthcare providers including but not limited to vaccinations, physicals, lab work and any other procedures necessary for diagnosis or treatment of my child.

I understand by signing this form it may be necessary for Regional Family Health/Regional Medical Center to share medical information concerning the patient named above to the following individuals:

Name	Relationship to Patient

Expiration:
This agreement will begin on _____, and shall remain effective until terminated by the undersigned or the minor reaches the age of majority.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Complete Mailing Address/Street/PO Box City/State/Zip Code