Group Health Cooperative
of South Central Wisconsin

Consent for Non-Emergency Care & Treatment of Minors to Temporary Caregiver(s)

Child's Last Name (PRINT)	Child's First Name (PRINT)	Date of Birth	GHC#
_____	_____	_____	_____

PARENT/GUARDIAN CONSENT FOR TEMPORARY CAREGIVER(S)

I hereby declare that I am the parent or legal guardian of the minor named above with the authority to grant the permissions described on this form. I hereby empower and grant to:

_____

Name and Relationship of Temporary Caregiver(s) – (Must be 18 years of age or older)

_____

Name and Relationship of Temporary Caregiver(s) – (Must be 18 years of age or older)

permission to consent and authorize medical treatment for the following type(s) of care:

Check one or more

☐ Primary Care	☐ Chiropractic	☐ Health Education	☐ Physical/Occupational Therapy
☐ Eye Care	☐ Lab Work	☐ Medical Imaging	☐ Complementary Medicine
☐ Mental Health	☐ Vaccines	☐ All types of services	

☐ Other: Describe):_____.

****Important Note: This form is not applicable for allergy injections. A parent/legal guardian must be present when a minor is given allergy injections. ****

This authorization shall be valid for the period of time commencing on _____

and ending_____. I do hereby indemnify and hold harmless the providers and other persons who act in reliance upon this authorization.

Executed this _____ day of _____, _____.

Signature of Parent or Legal Guardian	Relationship	DATE (mo/day/year)
_____	_____	_____

Send Completed Form To:
Group Health Cooperative of South Central Wisconsin
1265 John Q Hammons Drive
Madison, WI 53717-1962

Forward completed form to Health Information Department

MK20-38-0(4.20)F

This form is part of HID.069 and NUR.145. Any changes to this form that result in changes in procedure are to be documented in HID.069 and NUR.145.