

**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

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Health Education | <input type="checkbox"/> Physical/Occupational Therapy |
| <input type="checkbox"/> Eye Care | <input type="checkbox"/> Lab Work | <input type="checkbox"/> Medical Imaging | <input type="checkbox"/> Complementary Medicine |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Vaccines | <input type="checkbox"/> All types of services | |
| <input type="checkbox"/> 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)

****Parents/Legal Guardian Please Send Completed Form To: ****
Group Health Cooperative of South Central Wisconsin
5249 East Terrace Drive
Madison WI 53718

Forward completed form to Health Information Department

HID08-005-3 (4/09)