



## Authorize to consent to medical treatment of a child

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_ confirm that I have the legal right to consent to medical treatment of the minor child.

\_\_\_\_\_ was born on \_\_\_\_\_ and resides at the following address:

\_\_\_\_\_

I, \_\_\_\_\_, authorize Empowered Edge staff members to consent to emergency and routine medical treatment for my child in my absence while enrolled in the childcare home setting. This power of authority will be active beginning on the day of enrollment and will end on the last date of enrollment. To revoke consent, a written notification must be provided and signed by parent/guardian and provider.

I, \_\_\_\_\_, agree that this consent was given freely without coercion, duress, or payments of any kind.

Allergies to Medications:

\_\_\_\_\_

Current Medications:

\_\_\_\_\_

Insurance Number:

\_\_\_\_\_

Insurance Provider:

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_