

# LIFE MANAGEMENT FOR ADULTS, PLLC

P O Box 969, Portsmouth, NH 03802 | phone (603) 205-2953 / fax (888) 499-1213

## AUTHORIZATION FOR MINOR'S MEDICAL AND MEDICATION MANAGEMENT TREATMENT

**Child** Full Legal Name:

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Office Phone: \_\_\_\_\_ Doctor's Emergency Phone: \_\_\_\_\_

Medical Insurer/Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Allergies (Other): \_\_\_\_\_

If applicable, please note the conditions for which the child is currently receiving treatment: \_\_\_\_\_

Note any other significant medical information: \_\_\_\_\_

### Parent(s)/Legal Guardian(s):

**Parent #1:** Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

**Parent #2:** Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

### Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

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## AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for \_\_\_\_\_  
(hereafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing \_\_\_\_\_ Date: \_\_\_\_\_  
and Expiring on \_\_\_\_\_ Date: \_\_\_\_\_

### Electronic Signature of Parent #1 or Legal Representative\*

Please type your Full Name:

Date:

If signed by legal representative, relationship to patient:

Acceptance Checkbox \*  I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

### Electronic Signature of Parent #2 or Legal Representative\*

Please type your Full Name:

Date:

If signed by legal representative, relationship to patient:

Acceptance Checkbox \*  I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

OR PRINT, SIGN AND RETURN