Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

Addressograph or Label

CONSENTS • AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING AUTHORITY TO CONSENT

I, the undersigned, parent/person having legal custody/legal guardianship of the minor named above, do hereby authorize (name of agent) _____ to act as my agent(s) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, the child's physicians at LPCH whether such diagnosis or treatment is rendered at the hospital and clinics.

The undersigned understands that the patient may receive part of his/her care at Stanford Hospital and Clinics. The undersigned agrees that whenever the words "Lucile Packard Children's Hospital" or "hospital" appear in this consent, such words shall be construed to include, for such part of the patient's care, Stanford Hospital and Clinics.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deems advisable.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize LPCH which has provided treatment to the above-named minor pursuant to the provisions of Family Code section 6910 to surrender physical custody of such minor to the above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Health and Safety Code section 1283.

These authorizations shall remain effective until (month and day)_____, 20_____unless sooner revoked in writing delivered to the agent(s) noted above.

_____ _____ _____
SIGNATURE (Patient, Parent or Properly Designated Representative) Date Time

_____ _____
PRINT NAME OF SIGNATOR RELATIONSHIP to Patient

❑ **Telephone Consent Obtained by Practitioner**
2nd Witness **Signature** to Telephone Consent _____
Print Name and Title of 2nd Witness to Telephone Consent _____

MEDICALLY RELEVANT INFORMATION:

Allergies: ❑ No known drug, food, or environmental allergies ❑ Allergy alert (See LINKS)
Conditions for which minor is currently being treated: _____
_____
Current medications: _____
Restrictions on activity: _____
Primary care physician (name and telephone number): _____
Insurance company: _____
Mother's name: _____
Mother's telephone numbers: (Home) _____ (Work) _____ (Other) _____
Father's name: _____
Father's telephone numbers: (Home) _____ (Work) _____ (Other) _____