SUBSTITUTED CONSENT FOR
TREATMENT OF MINORS AND INCOMPETENTS

I, the undersigned parent/guardian of
Name and DOB: _____
Name and DOB: _____
Name and DOB: _____
Name and DOB: _____
Name and DOB: _____
Name and DOB: _____

AUTHORIZATION:
In the event that I cannot be contacted through reasonable efforts, hereby empower and grant permission to consent to and authorize medical and hospital treatment for my above named child/children. I authorize the following individuals.
Name and Phone Number_____
Name and Phone Number_____
Name and Phone Number_____

LIMITATIONS:
Identify any limitations on the kinds of medical services for which this authorization is given.
_____
_____
Identify any limitations on the time frame for which this authorization is given. If none, state "none." _____
I will hold harmless the providers at Watertown Family Practice Associates who act in reliance upon this authorization. I further agree to pay Watertown Family Practice Associates for the costs of rendering these services.
Executed this _____ day of _____, 20___.

_____ _____
Witness Parent/Guardian

_____
Parent

CONTACT INFORMATION:
Parent/Guardian may be located at the following address/telephone number:
Home Address/Telephone Number_____
_____
Cell Phone Number _____
Employer Name, Address and Telephone Number _____

_____