MĀLAMA I KE OLA
HEALTH CENTER

# AUTHORIZATION FOR TREATMENT OF A MINOR NOT ACCOMPANIED BY A PARENT OR GUARDIAN

I authorize permission for the following person(s): _____

_____

_____

_____

_____

to bring my child, _____ to Mālama I Ke Ola Health Centerin my absence for medical treatment. I authorize Mālama I Ke Ola Health Center's physician or mid-level provider to provide medical care, including but not limited to examination, treatment, x-ray procedure, laboratory tests, local anesthetics, diagnosis and hospital care.

**All authorized person(s) must present a photo I.D. when bringing in the child.**

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the provider or mid-level provider of Mālama I Ke Ola Health Center.

This authorization to treat will remain in effect until _____or unless I withdraw or cancel this authorization in writing.

My child has the following medical insurance: _____

The subscriber (name of the holder of the insurance card) is: _____

My phone number is: _____

_____ _____

Print name of Parent or Legal Guardian Date

_____

Signature of Parent or Legal Guardian