

CATSKILL REGIONAL MEDICAL CENTER

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
TEMPORARILY SEPARATED FROM PARENT/ GUARDIAN**

I/We, the undersigned, custodial parent(s)/guardian(s) of _____,
(Print Name of minor/minors)

a minor, do hereby authorize **Winston Day Camp** or any authorized representative thereof, as our agent(s) to act in my/our name, place and stead in any way in which I/we could do, if I/We were personally present , with respect to said minor, including, without limitation , giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon on the staff of or engaged by Catskill Regional Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at the Catskill Regional Medical Center.

With respect to consent to diagnostic procedures or medical care, it is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of my/our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his/her best judgement may deem advisable.

This authorization shall remain effective until **August** _____, **20**__, unless sooner revoked in writing and delivered to said agent(s).

(Signature of custodial parent or guardian) Date

(Signature of custodial parent or guardian) Date

(Witness) Date

Custodial Parent(s) /Guardian(s) Contact Information

Name: _____

Address: _____

Phone Numbers : Home: _____ Work: _____ Cell: _____

Insurance Carrier/Plan _____ Policy/I.D. _____

Insurance Company address & Phone # _____

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

