

Consent for Medical Treatment of a Minor Child

ALLEN PARK PUBLIC SCHOOLS

I (We), _____ and _____

I am (we are) the parents (s) or legal guardian(s) of _____

A minor, age _____, born _____ 20____, _____
(month, day) (street address)

(city, state)

The undersigned does hereby grant to the individuals listed below the limited Power of Attorney, to act for me and to give the required consents and authorizations for the delivery of medical care, diagnoses, and treatment, if necessary, for a period of time during my absence from **Sunday, August 20th** through **Thursday, August 24th**, under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of **Michigan** and do all other necessary things as I might or could do if personally present.

(Name of responsible adult) (Name of responsible adult)

The limited Power of Attorney is given pursuant to the provision of PA 1978, 642, Section 405 of the Probate Code and said Power of Attorney is not to exceed six months.

(Signature of Parent/Legal Guardian) (Relationship to Child)

(address) (phone – home and work)

Date this _____ of _____, 20**23**.
(day) (month)

Private Physician: _____ Phone: _____

Insurance: _____
(company and number)

Known allergies/significant medical history: _____

Last tetanus immunization: _____ Last Covid-19 Immunization _____

Phone number where parents can be reached: _____

Address where parents can be reached: _____

Subscribed and sworn to before me this _____ day of _____, 20**23**.

(Signature of Notary Public)

Notary Public, Wayne County, Michigan. My Commission expires _____

*****ALL OUT-OF-STATE FIELD TRIPS OR OVER NIGHT TRIPS
REQUIRE
THE NOTARY'S SEAL ON THIS FORM*****