VAIL Sitters
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Medical Treatment Form

Authorization to Consent to Treatment of a Minor

I (we), the undersigned parent(s)/guardian(s) of the minor(s) listed below, do hereby authorize:

_____ or
(family physician or pediatrician)

_____ or
(adult into whose care minor(s) is entrusted)

Physician in charge at:

_____
(name of children's physician or recommended hospital)

to act in my (our) place to consent to all necessary and appropriate X-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed to practice medicine under the laws of the state of Colorado.

It is understood that this authorization, which is valid for 12 months from the date below unless terminated sooner, is given in advance of any specific diagnosis, treatment or hospital care, but is given to provide authority and power on the part of my (our) aforesaid(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of their best medical judgment is deemed advisable, and is within sound medical practice in the community and is in the best interest of the child(ren).

Child(ren) 's Name(s)	Birth Date	Blood Type	Allergies

Address: _____ Phone: _____

Signed: _____ Date: _____
(Parent / Guardian)