U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-5484H (Rev. 04-05)	**CHILD DEVELOPMENT SERVICES** MEDICAL CONSENT AUTHORIZATION (TO BE USED BY **MILITARY** FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

TO: **HEALTH CARE PROVIDER**

I, _____ , am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: _____ , Age: _____

Address: _____ , Phone: _____

_____ , ID Card # _____

_____ , Exp. Date _____

_____	_____	_____
(Sponsor's Name)	(Employee ID Number)	(Duty Station)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the _____ Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____, 20_____ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on _____ , 20 _____ .

_____
Signature of Parent or Guardian

_____
Date

Approval Date _____

Chief, Medical Administration Branch
Health Services Division

This form shall be notarized.

State of _____)
) ss
County of _____)

On this _____ day of _____ , _____
(Month and Year) (Name of Notary Public)

a notary public (or person authorized to administer oaths under 10 U. S. C 1044a) for the County/City and State aforesaid,

certify that _____
(Name of Person executing Document)

who is known to me (by proper identification) to be the person whose name is subscribed to the within instrument and acknowledged that she executed the same for the purposes therein contained, as her free act and deed before me in the County/City and State aforesaid.

Sworn to and subscribed before me this _____ day of _____ .
(Month and Year)

_____
(Notary Public)

My Commission Expires: _____

Reset