

PROVIDENCE MEDICAL CENTER  
4805 N.E. GLISAN  
PORTLAND, OREGON 97213-2967  
PHONE: 503/230-1111

PROVIDENCE MILWAUKIE HOSPITAL  
10150 S.E. 32ND AVENUE  
MILWAUKIE, OREGON 97222  
PHONE: 5031652-6300

ST. VINCENT HOSPITAL AND MEDICAL CTR  
9205 SOUTHWEST BARNES ROAD  
PORTLAND, OREGON 97225  
PHONE: 5031297-4411

### ***AUTHORIZATION FOR ANOTHER TO CONSENT TO TREATMENT OF CHILD***

As a parent or legal guardian of the following children:

X \_\_\_\_\_

I hereby authorize -All Saints Extended Care

Name

601 NE Cesar E Chavez Avenue, Portland, OR 97232 (503) 314-9398

Address and Phone Number

who is 18 years of age or older, to consent to any medical or surgical treatment of above children which such person deems advisable. If a parent or legal guardian cannot reasonably be located when the children are brought for treatment.

The above authorization will be effective as September 1, 2017 and will expire after June 30, 2018

(Total period by law may not exceed six (6) month or twelve (12) months for school administrator.)

During this period the parent or legal guardian of the above children will be at the following location(s):

X \_\_\_\_\_

X Signature: \_\_\_\_\_

Witnessed by: \_\_\_\_\_

Home Address of Parent or Guardian: \_\_\_\_\_

Phone Number of Parent or Guardian: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Physician: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Dentist: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Child				
Chronic Illnesses or Allergies				
Date of Last D.P.T. Immunizations				
Other				