Winona Health

For Authorization to Treat a Minor or Dependent Adult (Parent or Guardian not present) refer to form 3352A.

Temporary Delegation of Medical Decision-Making for Minors or Dependent Adults

Anytime you are going to be separated from your children or those under your care, be sure to leave written permission for emergency treatment on file with Winona Health. By law, hospital emergency personnel cannot provide treatment in the event he or she becomes ill or injured, except in life or death situations, without parental/guardian authorization. With the proper consent on file, you ensure immediate care, should it be necessary in your absence.

1. **Complete both pages of this form and deliver it to Winona Health so it can be scanned into the electronic health record.**

2. **Keep a copy and give a copy to the adult(s) you have designated, explain its use and instruct them to bring this form with them if they are seeking treatment for the minor(s) or dependent adult(s) under their care.**

TELEPHONE NUMBER AND ADDRESS WHERE PATIENT OR GUARDIAN CAN BE REACHED:

Phone (_____) _____ Phone (_____) _____

Address:_____

HMO/INSURANCE/PRIMARY CARE PROVIDER INFORMATION:

Primary Care Provider:_____ Phone (_____) _____

Insurance:_____
Company

MINOR PATIENT OR DEPENDENT ADULT MEDICAL INFORMATION: (list each child/dependent adult)

Name(s) of Minor or Dependent Adult	Known Allergies/Drug Sensitivities	Known Medical Conditions	Last Tetanus Immunization

Patient ID Label

PO Box 5600 | 855 Mankato Avenue | Winona, MN 55987 | 507.454.3650 | 800.944.3960 | ***winonahealth.org***

Winona Health

Temporary Delegation of Medical Decision-Making for Minors or Dependent Adults

PERMISSION FOR TREATMENT

Name(s) of child/children/dependent adult(s): (please type or print legibly)

Last	First	Middle	Birthdate

Parent/legal guardian Giving consent (PRINT) **Last** **First** **Middle**

I am the parent or legal guardian of the above-mentioned minor child/children/dependent adult(s). I appoint the following individuals Limited Power of Attorney to act for me and to give the required consents and authorization for the delivery of medical care, diagnoses and treatment, including surgical intervention, if necessary, on behalf of my minor child/children or dependent adult(s):

NAME OF RESPONSIBLE ADULT	PHONE NUMBER	NAME OF RESPONSIBLE ADULT	PHONE NUMBER

I authorize the above permission for a period of time during my absence from _____to_____ (not to exceed 12 months) and to do all other necessary things as I might or could do if personally present. I understand this delegation includes receiving health information about the minor necessary to make health decisions.

INSTRUCTIONS: At least one parent or legal guardian must sign this form AND obtain signatures for either options 1 or 2.

PARENT OR GUARDIAN DATE TIME

PARENT OR GUARDIAN DATE TIME

2079A
11/9/2020

Patient ID Label

Option 1: Two witness signatures are required. The witnesses should NOT be employed by Winona Health, related by blood or marriage, or listed above as being delegated consent:

WITNESS DATE

WITNESS DATE

OR Option 2: *On this day, before me, the undersigned Notary Public, the parent(s) or guardian(s) herein named personally appeared and freely executed this document. He/she/they are personally known to me or has/have provided satisfactory evidence of their identity.*

Notary Public

SIGNATURE DATE