

**PROVIDENCE  
 PORTLAND MEDICAL CENTER**  
 4805 N.E. GLISAN  
 PORTLAND, OREGON 97213-2967  
 PHONE: 503/215-111

**PROVIDENCE  
 MILWAUKIE HOSPITAL**  
 10150 S.E. 32ND AVENUE  
 MILWAUKIE, OREGON 97222  
 PHONE: 503/652-8300

**PROVIDENCE  
 St. VINCENT MEDICAL CENTER**  
 9205 SOUTHWEST BARNES ROAD  
 PORTLAND, OREGON 97225  
 PHONE: 503/216-4411

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

As a parent or legal guardian of the following children:

\_\_\_\_\_ NAMES  
 I hereby authorize St. Agatha School  
 \_\_\_\_\_ NAMES  
7960 SE 15th Ave. Portland, OR 97202 ADDRESS 503-234-5500 PHONE NUMBER

who is 18 year 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 of: 9/6/2011 and will expire after 6/15/2012.  
 (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):

Signature: \_\_\_\_\_ or \_\_\_\_\_  
FATHER / GUARDIAN MOTHER / GUARDIAN

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 / AGE ▶			
Chronic Illness or Allergies ▶			
Current Medications ▶			
Date of Last D.P.T. Immunizations ▶			
Other: ▶			

**AUTHORIZATION TO TRANSPORT CHILD**

I give St. Agatha Catholic School permission to have my above named child/children transported to a hospital by ambulance for emergency medical care.

Signature of parent: \_\_\_\_\_ Date: \_\_\_\_\_