Annual Guardian's Permission to Treat

Name of Ward _____

Home provider name _____

I give my permission for the above-named provider or any employee of the provider to take the following actions on behalf of my ward, as indicated by my initials for each type of permission. This permission is granted with the understanding that I will be contacted as soon as possible prior to or following each event.

Routine Medical Permission to take my ward to the hospital, doctor or dentist for routine medical/dental care including but not limited to check ups, medical tests, lab work, X-rays etc., and to share relevant health information, with the understanding that I will be contacted as soon as possible after each visit.

_____approve _____refuse

Emergency Medical Permission in case of illness or injury requiring medical attention, to obtain treatment from the nearest hospital or doctor, with the understanding that I will be contacted as soon as possible.

_____approve _____refuse

Medication Administration Permission to assist with the administration of prescribed medication . I also give authorization to administer non-prescribed medication in accordance with guidelines outlined in the Over the Counter Medication Form filled out by the doctor.

_____approve _____refuse

Permission to make Medication Changes in case of any medication changes or additions or a prescribed treatment, as ordered by medical professional through phone contact with me. In the event that I am not immediately available, I give permission to implement any changes in medication with the understanding that I will be contacted as soon as possible.

_____approve _____refuse

This permission may be withdrawn at any time, or expires one year from date of signature.

Guardian:_____ Date:_____