



**GOING AWAY  
WITHOUT THE KIDS?**



**MUNSON HEALTHCARE**

*Your Health...Our Mission*

Telephone number and address where parent or guardian can be reached:

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Address: \_\_\_\_\_

Private Physician: \_\_\_\_\_

Insurance: \_\_\_\_\_  
Company Number

Known Allergies/Significant Medical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Last Tetanus Immunization (list for each child): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**GOING ON VACATION?**

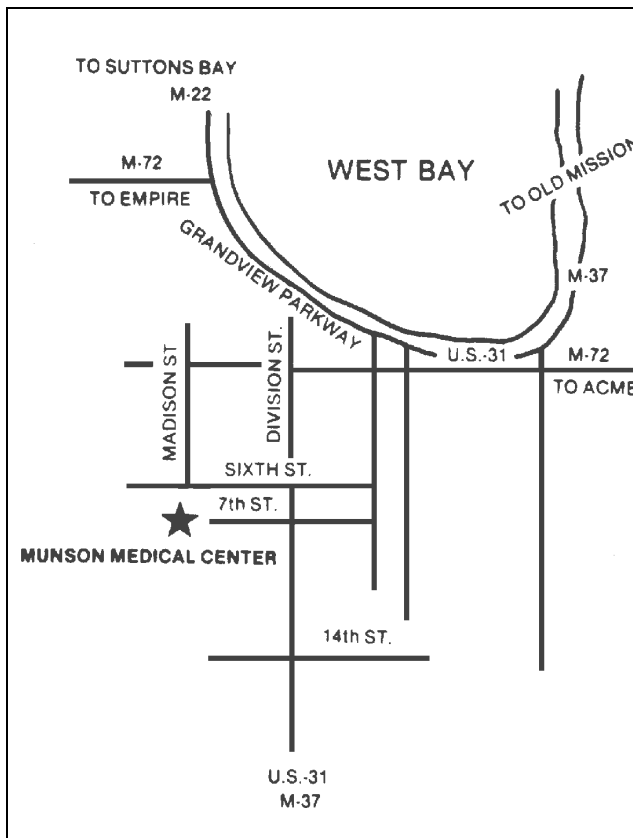
Anytime you are going to be separated from your children, be sure to leave written permission for emergency treatment on file with Munson Healthcare. By law, hospital emergency personnel can do nothing for your child in the event he or she becomes ill or injured, except in life or death situations, without parental authorization. Your child's care could be needlessly delayed while the hospital attempts to contact you. With the proper consent on file, you assure your child of immediate care should it be necessary in your absence. Complete the form below and send or bring it to the Emergency Department. Remove this portion of the sheet to serve as notice for those caring for your child that consent is on file, which facility it is on file with, and to familiarize them with the location of the Munson Healthcare facility.

**MUNSON MEDICAL CENTER**  
 1105 SIXTH STREET  
 TRAVERSE CITY, MI 49684-2386  
 (231) 935-5000

**MUNSON URGENT CARE**  
 550 MUNSON AVE  
 TRAVERSE CITY, MI 49686  
 (231) 935-8686

**KALKASKA MEMORIAL HEALTH CENTER**  
 419 S. CORAL ST.  
 KALKASKA, MI 49646-9438  
 (231) 258-7500

**PAUL OLIVER MEMORIAL HOSPITAL**  
 224 PARK AVENUE  
 FRANKFORT, MI 49635  
 (231) 352-9621



**EMERGENCY ROOM TREATMENT PERMIT/LIMITED POWER OF ATTORNEY**

*Please Type or Print*

Name(s) of Child or Children:

_____	_____	_____	_____
LAST	FIRST	MIDDLE	BIRTHDATE
_____	_____	_____	_____
LAST	FIRST	MIDDLE	BIRTHDATE

Name of Person giving Consent (PRINT) \_\_\_\_\_  
 LAST FIRST MIDDLE

The undersigned does hereby grant to the individuals listed below, (name two adult individuals who will be responsible for the care of your child or children in your absence.).

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

Or in the event neither of these individuals is available, I hereby grant the following individuals, (please indicate).

Munson Healthcare, Physician/Provider

the limited Power of Attorney to act for me and to give the required consents and authorizations for the delivery of medical care, diagnoses and treatment, including surgical intervention, if necessary, in behalf of my minor children listed above:

for a period of time during my absence from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed 6 months) and to do all other necessary things as I might or could do if personally present.

This limited Power of Attorney is given pursuant to the provisions of PA 386 of 1998, Sec 700.5103 of the Estates and Protected Individuals Code and said Power of Attorney is not to exceed six months.

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ PARENT OR GUARDIAN \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ by \_\_\_\_\_  
 (DATE) (NAME)

Notary Public, Grand Traverse County, Michigan  
 Acting in Grand Traverse County, Michigan  
 My commission expires: \_\_\_\_\_