1CONS

TRINITY REGIONAL MEDICAL CENTER
FORT DODGE, IOWA 50501

To Whom It May Concern:

This is to certify that I/we _____ of the person(s) listed below,
mother/father/legal guardian (circle one)

do hereby constitute and appoint _____
name(s) in full *address* *phone*

my/our true and lawful attorney, solely, and with the power to authorize and consent to the administration of any anesthetic or medical treatment to, and the performance of whatever operations or removal of tissue decided to be necessary by my physician(s) _____ or the E.R. Physician on the below named minor(s) for the period from _____ to _____ inclusive, not to exceed 30 days.

Name	Birthdate	Allergies	Tetanus Status	Current Meds

Witnessed By: _____ Signed _____
Parent(s)/Guardian

Date _____ Date _____

Entrustment of Care of Minors
EMD-14-1 9/2005

Patient Label