Authorization for Patient’s Leave of Absence for Therapeutic Purposes

I, the undersigned, understand that my child ___________________________ will be permitted by the attending doctor(s) to be absent from ___________________________ for various periods of time as noted hereunder as part of a planned therapeutic program. I request that such leave(s) of absence be granted, but recognize that they may not exceed 72 hours.

During any absence I agree to be solely responsible for the care of my child and relieve the attending doctors, the hospital, its employees, servants and agents, of all responsibility whatsoever for my child’s care and treatment. I agree to ensure that my child takes all prescribed medications at the times required and to follow the care instructions given by staff. I will immediately seek medical assistance for my child and return my child to the hospital if my child’s medical condition changes or if my child fails or refuses to comply with medical advice or care instructions.

I understand that I may designate a responsible adult as an alternate caregiver for my child during any leave of absence. I understand that I will remain responsible for the care of my child regardless of my appointment of an alternate caregiver.

I agree to remove any valuables from the hospital during my child’s absence from the hospital. I understand that the hospital is not responsible for any property owned by me or my child if left at the hospital during any absence.

Date ___________________________

Name(s) of alternate caregiver(s) appointed by parent (Print)

Parent/Guardian ___________________________

(printed name) ___________________________

(signature)

Witness ___________________________

(printed name) ___________________________

(signature)

Printed Name & Signature of parent/guardian/alternate caregiver for patients under 19 years of age

<table>
<thead>
<tr>
<th>departure</th>
<th>Expected return</th>
<th>Destination</th>
<th>Telephone number</th>
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<tbody>
<tr>
<td>Date/time</td>
<td>Date/time</td>
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Instructions given to patient/ parent/guardian/alternate caregiver

Date

Medications

Diet

Activity

Other

RN signature

Revised May 2011
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