Consent to Treat Minor Children

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____, and I am not reasonably available by telephone to give consent.

This authorization form is effective _____ to _____.

This consent form should be taken with the child to the hospital or physicians office when the child is taken for treatment.

This additional information will assist in treatment with consent but is not required

Family Address _____.
Telephone: Mother _____ home _____ work _____.
Father _____ home _____ work _____.

Child's Birthdate: _____ Last Tetnus _____.
Allergies to Drugs or Foods _____.

_____.

Special Medications, Blood Type or Pertinent Information:

_____.

_____.

Child's Physician _____ Phone: _____.
Insurance Carrier _____ Policy # _____.
Preferred Hospital _____.

_____ _____.

Name of Parent//Legal Guardian (please print) **Signature Parent//Legal Guardian**

_____ _____.

Witness Name (please print) **Witness Signature**