

CONSENT TO TREAT MINOR CHILDREN

Please print all information



I, _____, the 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 is effective from _____ to _____.

Signature of Parent or Legal Guardian

Name of Parent/Legal Guardian (please print)

Signature of Witness

Name of Witness (please print)

This consent form will be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address: _____

Parent #1 _____ (H) _____ (W) _____

Parent #2 _____ (H) _____ (W) _____

Child's Date of Birth: _____ Date of Last Tetanus: _____

Allergies: _____

Child's Physician: _____ Phone: _____

Preferred Hospital: _____

Insurance: _____ Policy #: _____

