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 is effective from _____ to _____.

_____

Signature of Parent or Legal Guardian

_____ _____

Witness Signature Witness Name (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 _____

Telephone: Father _____ home _____ work
Mother _____ home _____ work

Child's Birthdate _____ Last Tetanus _____
Allergies to drugs or foods _____
_____

Child's Physician _____ Phone _____
Insurance _____ Policy # _____
Preferred Hospital _____