CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to all medical care and the administration of anesthesia determined by the physician to be necessary for the welfare of my child while said child is under the care of **Western Ohio Podiatric Medical Center, Inc.** 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 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 food/drugs: _____

_____

Special Medications, Blood Type or Pertinent Information:

_____

_____

Child's Primary Care Physician: _____ Phone: _____

Insurance: _____ Policy: _____

Preferred Hospital: _____