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**Consent to Medical Care and Treatment of a Minor**

Complete this form and leave it with the person who is responsible for your child in your absence. In case of a medical emergency this form must be brought with the child to the clinic or hospital.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the natural parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment and procedures are immediately necessary or advisable in the interest of my child’s health. I understand that consent to treat is generally implied in emergency situations, and I waive my right of informed consent to such treatment as well as to further treatment that the physician would deem advisable during the time I cannot be contacted.

**The following individual(s) are authorized to bring the aforementioned minor child to their appointments.**

|  |  |  |
| --- | --- | --- |
| **Authorized individual(s)** | **Relationship to Minor** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:

Date: Termination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MINOR’S INFORMATION**

Name: Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies and Drug Reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Illnesses:

Regular Medications:

**EMERGENCY CONTACT INFORMATION**

Emergency Contact’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Telephone/Work: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_