

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born
the ___ day of _____, 20__ 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 _____ of
_____, City of _____ State of _____ and I am not
reasonably available by telephone to give consent.

This authorization is effective from the ___ day of _____, 20__ to
___ day of _____, 20__

Signature of Parent or Legal Guardian

Date

Witness Signature

Witness Name (please print)

This consent form should 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/Guardian Telephone: _____ Parent/Guardian Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____