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CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian

of _____, born

_____, do hereby consent to any medical 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 should be taken with the child to the 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 Date of Birth _____ Last Tetanus _____

Allergies to drugs or foods _____

_____

Special Medications, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____