PARENTAL/GUARDIAN MEDICAL CONSENT FOR A MINOR

I, _____, the parent or legal guardian of
print name of parent/guardian

_____ born on _____ do hereby consent
print child's name child's DOB

and designate _____ / _____ to handle any type of
designee's name relationship

medical care for my child including but not limited to the administration of anesthesia determined by a physician, surgery, and any other care recommended or deemed as necessary for the welfare of my child.

This authorization is effective from _____, 20___ and expires on _____, 20___.
date date

_____ _____
Signature of Parent/Guardian Date

This consent form should be taken with the child to the hospital or provider's office when the child is take for treatment. This additional information will assist in treatment it if can be furnished with the consent but is not required.

Primary Contact Telephone #: _____ Relationship: _____

Secondary Contact Telephone #: _____ Relationship: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy #: _____