

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, born \_\_\_\_\_, 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 \_\_\_\_\_ 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 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 \_\_\_\_\_

Telephone: Father \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_

Mother \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_

Child's Birthdate \_\_\_\_\_ Last Tetanus \_\_\_\_\_

Allergies to drugs or foods \_\_\_\_\_

Special Medications, Blood Type or Pertinent Information

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_