



CONSENT TO TREAT MINOR CHILDREN
Please print all information

I, _____, parent or legal guardian of
_____, born _____,
do hereby consent to any medical care and 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 (a copy of the parent's driver's license is recommended to accompany form)

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: _____

Street Address City State Zip Code

Telephone: Father: _____ (home/cell) _____ (work)

Mother: _____ (home/cell) _____ (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 _____

A copy of your insurance card(s), front and back, should accompany form.