



CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of
_____, born _____, do hereby
consent to any medical care 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 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 _____

Allergies to drugs or foods _____

Medications and Pertinent Information

Child's Pediatrician _____ Phone _____

Insurance _____ Policy # _____