

CONSENT TO TREAT MINOR CHILD

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)  
(by typing a name electronically, it is your signature here)

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 \_\_\_\_\_

ALL names + EMERGENCY #s we may call to attempt to reach you or a relative: