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 Insurance

Phone Policy #

Preferred Hospital