



### CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, \_\_\_\_\_, parent or legal guardian of the child listed below do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This authorization is effective from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Witness Name (Printed)

\_\_\_\_\_  
Witness Signature

*The information below is optional however it will assist in treatment of your child.*

Family address \_\_\_\_\_

Telephone: Father Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_

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

Special Medications, Blood Type or Pertinent Information: \_\_\_\_\_

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

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

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

***This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.***