CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized members of the clinic staff or their designees, as may in their professional judgment be deemed necessary 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

X_____ **Date: _____**

Witness Signature Witness Name (please print)

_____

Relevant Patient Information:

Family address _____
Telephone: Father _____ home _____ work
Mother _____ home _____ work
Allergies to drugs or foods _____
_____
Special Medications, Blood Type or Pertinent Information
_____
_____