



CONSENT FOR MEDICAL/SURGICAL CARE/EMERGENCY TREATMENT AND CHILD'S MEDICAL INFORMATION

PATIENT INFORMATION:

- Minor's Full Name: _____
- Date of Birth: _____ / _____ / _____
- Address: _____
- Phone Number: _____

PARENT/LEGAL GUARDIAN INFORMATION:

- Name: _____
- Relationship to Minor: _____
- Phone Number: _____

AUTHORIZED ADULT INFORMATION (If Applicable):

- Name: _____
- Relationship to Minor: _____
- Phone Number: _____

AUTHORIZATION FOR TREATMENT:

I, _____ (Parent/Legal Guardian), 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.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

I hereby give consent to **A+ FAMILY URGENT CARE, 3345 S DALE MABRY HWY, TAMPA, FL 33629** to provide routine or emergency medical care and treatment necessary to preserve the health of my child.

I accept responsibility for all reasonable charges in connection with care and treatment rendered during this period.

Signature of Parent/Legal Guardian

Date

MEDICAL & INSURANCE INFORMATION:

- Insurance Provider: _____
- Policy/Member Number: _____
- Primary Insured's Name: _____
- Child's Allergies: _____
- Child's Medications: _____