



CONSENT TO TREAT MINOR CHILDREN

Please print all information I, _____, parent or legal guardian of _____, 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, but it is not required:

Family address _____

Telephone: Father (home) _____ (work) _____ (cell) _____

Mother (home) _____ (work) _____ (cell) _____

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 _____