MEDICAL CONSENT FORM TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of_____, born

the___ day of_____, 20__ 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 _____of

_____, City of_____ State of_____ and I am not reasonably available by telephone to give consent.

This authorization is effective from the___ day of _____, 20___to

____day of _____, 20__

_____ _____

Signature of Parent or Legal Guardian ***Date***

_____ _____

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_____

Father's Telephone: _____Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy #_____

Preferred Hospital: _____