Consent for Medical Treatment of a Minor

I, ________________________, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by medical doctors, hospitals or their authorized designees, as may, in their professional judgement, be necessary to provide for the medical, surgical or emergency care of my child, ____________________________________(child's name and DOB).

I further give my consent to __________________________, who will be caring for my child for the period of _______________-_________________, to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my child.

In making medical decisions on my behalf for the benefit of my child, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give my permission to the caregiver to make such decisions regarding treatment as deemed appropriate by the medical doctor, hospital, or authorized designee. I authorize the caregiver to request, obtain, and review and inspect all information about my child that may be relevant to any decision to be made about treatment.

I acknowledge that no guarantee has been made to me as to the effect of such examinations or treatment on the condition of my child and that I am responsible for all charges in connection with the care and treatment provided to my child during this period.

Signature of legal guardian and date

____

Printed Name of legal guardian and date

____

Contact number ____

Witness Signature/Date____

*Please Attach a copy of your Driver's License and Medical ID Cards along with a list of all current medications, allergies, and diagnoses and name/number of Primary Care Physician.

** Please Complete Medical Information Sheet on next page.

Important Medical Information

Insurance Information

Insurance Company ____

Policy Number _______________________________

Group Number _______________________________

Subscriber Name ______________________________ Subscriber DOB __/__/___

Relationship to Patient __________________________

Primary Care Physician

Child's Physician ____________________________ Phone ___________________

Parent's Physician ___________________________ Phone ___________________

Current Medications

____

____

Allergies

____

____

Existing Diagnoses

____

____

Vaccines up to date Yes No Date of last Tdap (tetanus) ___/___/____