CONSENT 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 _ _ Parent/Guardian Telephone: _Parent/Guardian Telephone:

Last Tetanus: _

Allergies to drugs or foods: _ _

Special Medications, Blood Type or Pertinent Information: _

Child's Physician: _ _ Phone: _

Insurance: _ _ Policy # ___ Preferred Hospital: