

Consent To Treat Minor

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Parent/Legal Guardian Name *

Child's Name *

I now consent to any medical treatment, including but not limited to diagnosis, examination, and medical procedures, that may be deemed necessary or advisable by any licensed physician or medical facility for the health and welfare of my child.

I understand that medical treatment may include medication, surgery, or other medical procedures, and I authorize such treatment as deemed necessary by the medical professionals responsible for my child's care.

I further understand that unforeseen conditions or complications may arise during treatment, and I authorize the Physician or medical facility to take such measures as deemed necessary to protect the health and welfare of my child.

I agree to assume financial responsibility for all medical expenses incurred on behalf of my child and understand that payment for such services is due at the time they are rendered. I certify that I have the legal authority to provide this consent and that all information is accurate to the best of my knowledge.

Signature of Parent or Legal Guardian *

Date Signed *

The consent form should be taken with the child to the hospital or physician's office when the child is treated. This additional information will assist in treatment if it can be furnished with consent but is not required.

Family address

Telephone: Father home

Telephone: Father work

Telephone: Mother home

Telephone: Mother work

Child's Birthdate

Allergies to drugs or foods

Last Tetanus

Special Medications, Blood Type, or Pertinent Information

Child's Physician

Phone

Insurance

Policy #

Preferred Hospital