**Consent to Treat Minor Children**

Please print all information

I, [NAME HERE] parent or legal guardian of [NAME HERE], born [DATE], 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

[PHYSICIAN NAME], and I am not reasonably available by telephone to give consent.

This authorization is effective from [DATE] to [DATE].

|  |  |  |
| --- | --- | --- |
|  | | |
| Signature of Parent or Legal Guardian | | |
|  |  |  |
| Witness Signature |  | Witness Name |

*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 |  | | |
| Telephone: | Father: | Home: | Work |
| Telephone: | Mother: | Home: | Work |
| Child’s Birthdate |  | Last Tetanus: |  |
| Allergies to drugs or food | |  |  |
| Special Medications, Blood Type or Pertinent Information | | | |
|  | | | |
| Child’s Physician |  | Phone: |  |
| Insurance: |  | Policy # |  |
| Preferred Hospital |  |  |  |