Date: ___________________

Consent for Medical Treatment of a Minor Child

I/We, ____________________and ____________________who resides in the city of______________, county of ______________, and state of ______, do hereby state that I am (we are) the parent(s) or legal guardian(s) of ______________________, a minor age of ______, born ___________ who reside with me (us) at ____________________. I (we) authorize ___________________, an adult who resides at _________________________, in the city of _______________, county of ________________, state of ________ to consent to any and all necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine In the state(s) of________.

____

Signature of Parent(s) or Guardian   Date

____

Witness   Date

____

Family Doctor Contact Information

Medical Insurance Carrier: ___________________________
Identification Number: ___________________________
Member's Name: ____________________________
Benefit Code: ____________________________
Account Number: ____________________________
Medical History: ____
Chronic or existing diseases or medical problems: ______________________________________
____
Medication your child is currently taking: ____
Parent(s) contact information: ____
Guardian(s) contact information: ____