CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, ____, parent or legal guardian of ____, born _________________________, do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child. When the patient is accompanied by:

Full Name:____

Relationship to Patient:____

Address:____

Phone Number:____

This authorization is effective from ________________ to _______________.

Signature of Parent or Legal Guardian

______________________________ Date_____________________

Parent or Legal Guardian Name (please print)

____

Witness Signature

________________________________ Date_____________________

Witness Name (please print)

____