## CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, (We)		and					
of (name	e)		(name) ,, do hereby state (state)				
(city)	(county)	) (:	state)	<u>-</u>		,	
that I am (we are) th	ne parent(s) or legal guar	rdian(s) of					
		a minor child	age		born		
(name			~~~_	(age)	00111_	(date)	
who resides with me	(us) at					• ,	
	(street a						
I (We) authorize			an ac	dult,			
who recides at	(name)			•			
who resides at	(address)	-		n	:		
the city of	(address)	country of					
the only of	(city)		(0	County)		<del>-</del>	
state of	(0103)	to consent to any	nece	essary e	xamin	ation	
anesthetic medical of	liagnosis, surgery or trea	tment and/or ho	snital	care to	he re	ndered to	
the above-named mi	nor under the general or	snecial sunervision	on an Shimi	d on th	e advi	ce of any	
physician or surgeor	licensed to practice med	licine in the state	(e)	d On th	ic auvi	oc or any	
_		aromic in the state	(3)				
Date this	day of	20					
	duy or	20_					
Signature of	parent or guardian	Signature	e of r	arent c	ar oniar	dian	
	P	o Sincial.	or p	on one c	n 5uu	CICII	
	,						
БАМП V DOCTO	<b>∂</b> ₽.		المحما		-::	#:	
FAMILY DOCTOR:			Chronic or existing disease or medical problems:				
ADDDECC.		II	ieaica	ai prob	iems: _		
DRUME:		<del></del>					
rnone	99,000	<u> </u>					
MATTICAL INTOLE							
	RANCE CARRIER:						
Identification Number		<del></del>					
Members's Name: _		N	<b>ledic</b>	ine you	r child	is taking	
Account Number:		n	ow:_				
MEDICAL HISTOR		_					
Allergies, if any, incl	uding medication:	_					