CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, (We)_____ and _____
(name) (name)
of_____, _____, _____, do hereby state
(city) (county) (state)
that I am (we are) the parent(s) or legal guardian(s) of

_____ a minor child, age_____ born_____
(name) (age) (date)
who resides with me (us) at _____
(street address)
I (We) authorize _____ an adult,
(name)
who resides at _____in
(address)
the city of _____ county of _____
(city) (county)
state of_____ to consent to any 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_____

Date this_____ day of _____ 20_____

_____ _____
Signature of parent or guardian Signature of parent or guardian

FAMILY DOCTOR:_____

ADDRESS:_____
PHONE:_____

MEDICAL INSURANCE CARRIER:
Identification Number: _____
Members's Name: _____
Account Number:_____

MEDICAL HISTORY:
Allergies, if any, including medication:
_____
_____
_____

Chronic or existing disease or medical problems: _____
_____
_____

Medicine your child is taking now:_____
_____
_____
_____
_____
_____
_____