CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR

Hospitals and clinics are unable to treat or care for minors (children) without **consent form** parents or legal guardians. This can cause problems if the child has a medical emergency when parents or guardians are not readily available for **consent**.

Complete this **form** and leave it with the person who is responsible for your child in your absence. In care of a medical emergency, this **form** must be brought with the child to the hospital or clinic.

I, ____________________ (PLEASE PRINT) , the natural parent/legal guardian of ______________________ (PLEASE PRINT), authorize and **consent** to medical, surgical and hospital care, **treatment** and procedures to be performed by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, **treatment** and procedures are immediately necessary or advisable in the interest of my child's health and well-being.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed **treatment**, its anticipated results, possible alternatives, and the risks, complications, and anticipated benefits involved in the proposed **treatment** and the alternative forms of **treatment**, including non-**treatment**.

Date ____________________ Termination Date ___________________

Signature of Parent/Guardian ________________________

Witness ____

Please provide the information requested on Page 2 of this form.

INFORMATION ON THE MINOR

Minor's Name ________________________________

Date of Birth _____________

Allergies and Drug Reactions:

Chronic Illnesses:

Regular Medications:

Blood Type:

Date of Last Tetanus Immunization:

Other Pertinent Data:

Child's Physician _________________________________

Physician's Phone Number _________________________

Parent's or Guardian's Address:______________________
____

Parent or Guardian's Home Phone Number ____________
Parent or Guardian's Work Phone Number _____________

Insurance Coverage :
Group Number _________________
Membership Number _______________
Employer ________________________