

CONSENT TO MEDICAL TREATMENT

I, _____, parent or legal guardian of _____, born
the ____ day of _____, 20____ do hereby consent to any medical care determined by a
physician to be necessary for the welfare of my child while said child is under the care of
_____ of _____, City of _____ State of _____
and I am not reasonably available by telephone to give consent.

This authorization is effective from the ____ day of _____, 20____ to
____ day of _____, 20____

Signature of Parent or Legal Guardian

Date

Witness Signature

Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____