CONSENT TO TREAT MINOR CHILDREN

I, _____, and _____ the parent or legal guardians of

_____, a child born on the___ day of_____, 20__ do hereby allow and consent to any necessary medical care and, if required, the usage of anesthesia that has been determined to be necessary by a physician for the wellbeing of my child or ward. This consent is valid while the child is under the care of

_____ with the address of _____ City of _____ State of

_____ and I am unable to be contact to any medical care andthe administration of anesthesia 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 attempts to contact me via phone to provide consent have proven ineffective.

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)

Note that this consent form should be taken, along with the child, to the hospital and or the physician's office at any time the child is going for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address_____

Parent/Guardian Telephone: _____ Parent/Guardian Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

_____

Special Medications, Blood Type or Pertinent Information: _____

_____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy #_____

Preferred Hospital: _____