



Consent for Treatment of a Minor Child

I, (We) _____
(name)
and _____
(name)
of _____
(city) / (county) / (state)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of:

(child's name)
a minor, aged _____, born _____,
(age) (date of birth)
who resides with me (us) at

(address)

I (We) authorize the adult,

(name)
who resides at

(address)
in the city of _____,
county of _____,
state of _____

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s) during the periods(s) of my/our absence from:

_____ through _____
(month) / (day) / (year) (month) / (day) / (year)

In no event shall this delegation of parental rights be effective for more than six months.

(date)

(signature of parent or guardian)

(signature of parent or guardian)



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This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as medical, dental, surgical care or hospitalization may be required.

Allergies:

Chronic diseases or medical problems:

Medicines child is now taking:

Family Physician:

Telephone:

Medical Insurance Carrier or Government Program:

ID Number:

Member's Name:

Benefit Code:

Account Number:

Parents may be reached as follows:
