CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of_____, born
(please print) (please print)

the___ day of_____, 20__ do hereby authorize _____ of
(please print)

_____to consent on my behalf to any medical treatment
(address of authorized person)

for my child if I am not reasonably available by telephone to give consent.

This authorization is effective from _____ to_____, one year maxium.

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____Witness
Signature Witness Name (please print)

This consent form should be taken with the child to the 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_____

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

Allergies to drugs or foods: _____

Special Medications or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Child's Pharmacy: _____ Phone:_____