



MEDICAL CONSENT TO TREAT FORM

Patient's Name: _____ **Date of Birth:** _____

Medical authorization for others to consent to treatment of a minor child

I authorize _____ to obtain medical care for the children named above, and I consent to hospitalization of, the performance of necessary diagnostic tests upon, and the use of surgery on, and/or administration of drugs to the child if an illness or emergency occurs when I can not be immediately contacted.

Authorized Caregivers Phone: _____

Expiration (if applicable): _____

Signature of Parent/Guardian: _____

Date: _____