CONSENT TO TREAT MINOR CHILDREN

Please print all information

I _____, parent or legal guardian of _____, born on _____, do hereby consent to any medical care determined by a provider of ABC Pediatrics to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available to attend his/her appointment.
This authorization is effective from _____ to _____.

_____

Signature of Parent or Legal Guardian

_____ _____

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 _____
Telephone: Father _____ home _____ work
Mother _____ home _____ work

Child's allergies to medications or foods _____
_____

Current Medications or Pertinent Information _____
_____
_____

Child's Insurance _____ Policy # _____
(You must send insurance card with the child to appointment.)