Daniel Tulip, MD
Janet Shen, MD
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CONSENT FOR THE TREATMENT OF A MINOR

In the event that neither parent nor guardian is available at the time consent for treatment is needed, this consent will be in effect starting this day, _____ and ending,_____ (or 90 days from the date of signature). The authorized adult should be prepared to verify his or her identity to correspond with the names stated in this authorization, should the need for medical care arise.

I authorize _____ to give consent for medical treatment of my child/children.
(Must be 19 years or older)

The authorized person's home address: _____

The authorized person's Cell Phone:_____ Work Phone:_____Home Phone:_____

Child Name	DOB	Chronic Illness	Allergy

Parent/Guardian Home Address: _____ Phone _____

Health Insurance Company: _____ Phone _____

Signatures _____and/or _____
Father/Guardian Date Mother/Guardian Date