Consent for Medical/Urgent Treatment and Child's Medical Information

SILVER PINE MEDICAL GROUP

In presenting my son/daughter for diagnosis and treatment

Name: _____for _____ Date of Birth _____
☐ Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter MM/DD/YYY

Hereby voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment, by authorized members of the medical practice staff or their designee, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to _____
(Name of Person/Name of Medical Practice)

who will be caring for our (my) child _____
(Name of Child)

for the period _____ to _____ to arrange for routine or urgent medical care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____ Telephone no.:_____

Address: _____ City: _____ State: _____ Zip: _____

Name of health insurance carrier: _____ Subscriber: _____

Group no.: _____ Policy no.: _____

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Name: _____
Mother, Father or Legal Guardian

In case of emergency I can be reached at: _____

_____

_____

Witness: _____ Date: _____