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MEDICAL CONSENT (FOR A MINOR)

I, _____, the parent/legal guardian of _____ residing at

_____

born on the _____day of _____, 20_____ do hereby consent and allow

_____ to handle any type of medical care including but not limited to treatment.

This authorization is effective from on this _____ day of _____, 20_____ and

expires on the _____ day of _____, 20_____.

_____ _____ _____
Signature of Parent/Legal Guardian **Date** **Print Name**

_____ _____ _____
Signature of Parent/Legal Guardian **Date** **Print Name**

The additional information provided will be used as a source in the case of an emergency or if a medical decision needs to be further discussed with a parent of legal guardian.

Mother/Legal Guardian's Name: _____ Phone: _____

Father/Legal Guardian's Name: _____ Phone: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____ Group # _____