FIRSTCARE
MEDICAL CENTERS, LLC.

CONSENT FOR TREATMENT OF A MINOR

This authorizes_____ or _____
Names of Adults over 19 Years

To give consent for medical or surgical treatment for our child(ren)
Give names and birthdates:

_____ _____

_____ _____

In the event that neither Parent/Guardian is available at the time such consent for treatment is needed. This consent will be in effect between _____ and _____. The authorized adult(s) should be prepared to verify his/her identify to accord with the names stated in the authorization.

_____ or _____
Signature Father/Guardian Signature Mother/Guardian

Witness_____
Parent/Guardian Home Address_____
Work Phone_____Home Phone_____
Employer _____
Alternate Emergency Contact _____
Health Insurance Company _____
Policy Number_____Member Number_____
Billing Address _____
Chronic Illnesses or Allergies _____
_____
_____
Medications _____
Private Physician_____Phone_____