



## 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.

\_\_\_\_\_  
Signature Father/Guardian or \_\_\_\_\_  
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 \_\_\_\_\_