

## CONSENT FOR TREATMENT OF A MINOR

This authorizes	or
	Names of Adults over 19 Years
To give consent for medical Give names and birthdates:	or surgical treatment for our child(ren)
——————————————————————————————————————	
In the event that neither Der	rent/Guardian is available at the time such consent for
	nsent will be in effect between
	e authorized adult(s) should be prepared to verify
his/her identify to accord with	th the names stated in the authorization.
	or
Signature Father/Guard	ian Signature Mother/Guardian
Witness	
Parent/Guardian Home Adda	ress
	Home Phone
Employer	
Alternate Emergency Contac	et
Health Insurance Company _	
Policy Number	Member Number
Chronic Illnesses or Allergie	es
Private Physician	Phone