AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINORS

As the parent/guardian of ____,
I give my consent for any X-Ray, examination, anesthetic, phlebotomy, medical or surgical diagnosis and/or treatment rendered to the above-named minor under general or special supervision of, and pursuant to the advice of his/her physician.

I acknowledge that the provider has fully explained the risks and benefits of the procedure/treatment and that I have had all questions about the procedure/treatment answered to my satisfaction. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee as to the outcome of any procedure, treatment or examination has been made to me.

Executed on this date: ________________________________

____
Witness

____
Parent/Guardian

Parent/Guardian can be located at the following phone number and address:

____
Phone Number

____
Secondary Number

____
Address

Primary Care Doctor Information:

____
Phone Number

____
Address

Any known allergies: ____

Medications child is taking: ____

Insurance Company: ____

Insurance Policy Number: ____