



Consent to Treatment of a child by Authorized Persons

The undersigned parent or legal guardian of _____ (child's name) authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____ (phone number).

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

Name: _____ Relation to child: _____ Ph# _____

Name: _____ Relation to child: _____ Ph# _____

Name: _____ Relation to child: _____ Ph# _____

2. Medical concerns: _____

3. Known allergies: _____

Name of Parent or Legal Guardian: _____ (print name)

Relationship to child: _____

Contact Number(s): _____

Address: _____ City, State, Zip: _____

Signature: _____ Date: _____

*This consent is effective until withdrawn in writing by the child's parent or legal guardian.