QUINCE ORCHARD
MEDICAL CENTER

CONSENT TO TREAT A MINOR CHILD

I, _____, being the parent or legal guardian of,

_____ _____
Print Name of Minor Minor's Date of Birth

give my consent for routine medical treatment of this minor at Quince Orchard Medical Center (QOMC) per the judgment of a QOMC health provider. As long as the medical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations/prohibitions, specify here:

_____

_____

_____

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

_____ _____
Signature (Parent or Guardian) Date

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Home Telephone: Work Telephone

If this is a verbal / phone authorization:

_____ _____
Signature of QOMC staff receiving authorization Signature of Witness to the verbal/phone authorization