FINDLAY Women's Care™
OBSTETRICS | GYNECOLOGY | MIDWIFERY

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Findlay, OH 45840

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FindlayWomensCare.com

CONSENT FOR TREATMENT OF MINOR

I hereby grant the Physician's employed by Findlay Women's Care authority to give an informed consent for treatment of

______________________________, ______________________________
(Child's Name) (Age)

Should my child require medical care of any nature by reason of any condition or incident, except that the following procedures should not be performed without consent, unless the concurring medical opinion of two physicians is that such procedures are necessary to relieve suffering or preserve the life or limb of such child and I cannot be reached after reasonable attempts:

A. Major Surgery

B. ______________________________
(Specify)

Facts concerning my child's medical history, including allergies, physical impairments and medications being taken, to which a physician should be alerted are as follows:

____

____

Our family physician is Dr. ______________________________ Phone:______________

Our family dentist is Dr. ______________________________ Phone:______________

Our hospital choice is:______________________________

Our health insurance plan is: ______________________________

This authorizations expires on ______________________________, 20 __________
(Month) (Day)

____
(Witness)

____
(Signature of Parent/Guardian) (Date)

Address______________________________

____

Home Phone: ______________________________

Work Phone: ______________________________