City Care Family Practice, P.C.
461 Park Avenue South, 9th Floor
New York, NY 10016-7570
Phone 212-545-1888
Fax 212-545-1919

CONSENT TO TREAT MINOR PATIENT

Patient's Name: ________________________________ **Date of Birth:** ___________

I hereby consent to the medical care and the administration of vaccinations determined by the healthcare provider to be necessary for the welfare of my child while said child is under the care of the person listed below while I am not reasonably available by telephone to give consent.

Name of Authorized Person: ___________________________________

Phone #: ________________________________

Signature of Parent/Legal Guardian: _____________________________

Name of Parent/Legal Guardian: ________________________________

Phone #: ________________________________

Date: ________________________________

The authorized person should bring this consent form with the child at the time of his/her appointment at City Care Family Practice.

This additional information will assist in treatment if it can be furnished with the consent.

Current Medications: ____

Allergies to drugs or foods: ____

Other important medical information if any: ____

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