PARTNERS IN FAMILY HEALTH, PC

CONSENT TO TREAT MINOR CHILDREN

(Please print all information)

I,_____, parent or legal guardian of _____, born _____, do hereby consent to medical care (including the administration of local anesthesia and therapeutic and immunization injections) determined by a physician to be necessary for the welfare of my child while said child is under the care of_____ and I am not reasonably available by telephone to give consent.

The authorization is effective from _____ to _____.

_____

Signature of Parent or Legal Guardian

_____ _____

Witness Signature Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment, but is not required.

Family address: _____

Telephone: Father_____home _____work

Mother_____home _____ work

Child's Birthdate _____ Last Tetanus_____

Allergies to drugs or foods

_____

_____.

Special Medications, Blood Type or Pertinent Information

_____

_____

_____.

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____