

# Consent for Treatment of a Minor

Date \_\_\_\_\_

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, give my consent for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and hospital personnel the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write NONE):

\_\_\_\_\_.

My consent is effective for the following time period: From \_\_\_\_\_ to \_\_\_\_\_.

Signature of Parent or Legal Guardian: \_\_\_\_\_.

## Parent / Legal Guardian

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Workplace: \_\_\_\_\_

Phone: \_\_\_\_\_

## Mother's / Legal Guardian's Workplace

Name: \_\_\_\_\_

Phone(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Workplace: \_\_\_\_\_

Phone: \_\_\_\_\_

## Father's / Legal Guardian's Workplace

Name: \_\_\_\_\_

Phone(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Workplace: \_\_\_\_\_

Phone: \_\_\_\_\_

## Other Contact Person

Name: \_\_\_\_\_

Phone(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Medical Insurance Carrier

Company Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

## Family Doctor

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## Preferred Surgeon

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Preferred Hospital:

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Phone: \_\_\_\_\_

## Medical History

Allergies and Allergies to Medication: \_\_\_\_\_

\_\_\_\_\_

Chronic or existing medical conditions and problems (such as diabetes, epilepsy): \_\_\_\_\_

\_\_\_\_\_

Medication child is now taking: \_\_\_\_\_

\_\_\_\_\_

Other important information: \_\_\_\_\_

\_\_\_\_\_

If parent or legal guardian is out of town, list where and when you/he/she can be reached (list dates, times, locations and phone numbers):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

