Consent for Medical Treatment of a Minor

(Name)_____has my permission to obtain medical treatment services for my child ;(name) _____.

Mother/Guardians Name: _____

Address: _____

Home Phone: _____ Cell Phone_____

Insurance Provider Name: _____

Insurance member#:_____ Group: _____ Employer's name:_____

A copy of a current insurance card must be included with this form.

Fathers/Guardian Name: _____

Address: _____

Home Phone: _____Cell Phone: _____

Insurance Provider Name: _____

Insurance member#:_____ Group: _____ Employer's name: _____

A copy of a current insurance card must be included with this form.

Child's Allergies: _____, _____, _____

Child's Medications: _____, _____, _____

_____, _____, _____, _____

Primary Physician's Name: _____

Phone number: _____

I understand that I assume all financial responsibility for any treatment obtained by this authorized caregiver.

Signature Date

Signature Date

This form is valid for these dates of service: _____ to _____.

2/2018