CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of medications and vaccines 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 phone to give consent.

This authorization is effective for 1 year (365 days) from the date of the signature.

Signature of Parent or Legal Guardian **Date**

_____ _____

Witness Signature **Witness Name (Please Print)**

The following information will assist in treatment if available with the consent but is not required.

Family Address:_____--
Home Phone:_____
Alternative Phone:_____

Date of Birth:_____
Last Tetanus:_____
Food or Drug Allergies:_____

Child's Primary Care Physician:_____ Phone:_____
Insurance:_____ Policy Number:_____