Parental Consent/Medical Treatment Form

Name of Minor_____Age____Date of Birth_____
Address_____
Parent/Guardian_____
Home Phone_____
Work Phone_____Cell Phone_____

I (we) give permission for _____ or _____ my (our) consent to secure medical treatment and/or to order prescriptions, anesthesia, or surgery for my child as deemed necessary by a qualified physician. I (we) understand that my (our) insurance coverage for my (our) child will be used as primary coverage in the event medical intervention is needed. I (we) the undersigned shall agree to pay expenses incurred in connection with such medical services rendered to the child pursuant to this authorization.

Insurance Company_____
Policy Number_____
Name of Policy Holder_____
Physician_____
Physician's Phone_____

Please list any existing medical condition, significant allergies or other medical facts that a physician might need to know.

Parent/Legal Guardian Signature

Date_____