

Advance Consent to Treat a Minor

Patient Name _____
Last First MIDate of Birth _____
mm/dd/yyyy

AUTHORIZATION

I, the parent or legal guardian of the minor listed above, hereby authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

Signature_____
Date_____
Print Name_____
Relationship to Minor (parent, guardian, or other legally authorized individual)_____
Address: Street or P.O. Box_____
City, State, ZIP_____
Phone