CONSENT TO TREAT MINOR CHILDREN Please print all information

| I, | | | , parent or leg | gal |
|-------------------|--|-----------------|-----------------------------|--------|
| | · | | | born |
| | , do h | ereby consent | t to any medical care an | nd |
| | stration of anesthesia det | | | ary |
| for the welf | fare of my child while sa | | | |
| | | and I am | not reasonably available | ole |
| by telephon | e to give consent. | | | |
| This author | ization is effective from | | to | |
| | | | | · |
| Signature o | f Parent or Legal Guardi | an | | |
| | | | | |
| Witness Signature | | Witness Na | Witness Name (please print) | |
| | nsent form should be ta tysician's office when th | | 1 | |
| This addition | onal information will ass | ist in treatmen | nt if it can be furnished | l with |
| the consent | but is not required. | | | |
| T '1 11 | | | | |
| | ress | | 1- | |
| Telephone: | Father Mother | | | |
| | | | work | |
| Child's Birthdate | | Last Tetanus | | |
| | o drugs or foods | | | |
| | | | | |
| ~ | | | | |
| Special Me | dications, Blood Type or | r Pertinent Inf | formation | |
| | | | | |
| Child's Physician | | | Phone | |
| | | | | |
| | lospital | | | |
| | | | | |