CONSENT TO TREAT MINOR CHILD

Please print legibly

(This form must be filled out **completely**)

I, _____ am the parent or legal guardian
(parent or legal guardians name PRINTED)

of _____ whose date of birth is _____/ _____/_____,
(child's name coming for appointment)

do hereby consent to any medical care and/or administration of immunizations determined by a provider to be necessary for the health and welfare of my child while under the care of

_____.
(person bringing the child to appointment)

This authorization is effective form _____ to _____.
(start date of consent) (end date of consent)

_____ _____
(signature of parent/ legal guardian) (date)

_____ _____
(signature of witness) (witnesses name printed)

This form must be brought with the child to the providers' office when the child is taken for treatment. The child cannot be treated without this form if the parent or legal guardian is not with the child at the time of service.

Patient's address:
_____

Parent’s phone #: _____