PARENTAL CONSENT

FOR TREATMENT OF MINOR CHILDREN

I/We, ____, hereby certify that I/we am/are the parent(s), or legal guardian(s), of the following minor child:

Name: ___________________________ Date of Birth: __________________ Sex: _____

Parents' Contact Information:

Name(s): ____

Address: ____________________________ E-mail Address: _____________________

______________________________ Telephone Number: __________________

I/We consent to the medical care and treatment of my/our child by a physician in order to provide for such child's health and welfare, including in an emergency, if I/we am not readily available to provide such consent. I/We understand that such treatment may include anesthesia, the provision of fluids, hospitalization, blood transfusions, surgery, and/or the administration of medication.

My/Our child has the following conditions/requirements of which a medical provider should be aware:

_____ Special Medical Condition (specify): _____________________________________

_____ Allergies (specify): _____________________________________

_____ Medications (specify): _____________________________________

Initial one:

_____ This Consent is effective until it is revoked.

_____ This Consent is effective from the period of ___________ to _____________.

This Consent applies to all times when my/our child is under the care of the following person or entity:

Name: ______________________________ __________________________________

Address: ____________________________ E-mail Address: _____________________

______________________________ Telephone Number: __________________

My/Our child's primary physician or hospital is:

Name(s): ____

Address: __________________________ E-mail Address: ____________________

__________________________ Telephone Number: _________________

I/We authorize the contact of my/our child's primary physician or hospital in order to render treatment, and I/we authorize the disclosure of any health information necessary to treat such child.

Such child is insured as follows:

Insurer: ________________________________ Policy/Group Number: _________________

DATED:___________________

____
Signature of Parent or Legal Guardian

DATED:___________________

____
Signature of Parent or Legal Guardian

Subscribed and sworn to before me

this ____day of __________________, 20___.

____
NOTARY PUBLIC

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If you want to learn more about Release of Liability, read more in our general category

Release of Liability Templates.

Click the following link to find out more details about HIPAA Medical Release Form.

Find out more about Child Medical Release Template.