



Treatment Consent for Minor Child or Patient with Guardianship

Patient's Name:	Date of Birth:	Sex:
Street Address:	City & State:	Zip Code:
Phone:	Allergies:	

Parent/Legal Guardian 1:	Relationship:	Phone:	Alt. Phone:
Street Address:	City & State:		Zip Code:
Parent/Legal Guardian 2:	Relationship:	Phone:	Alt. Phone:
Street Address:	City & State:		Zip Code:

Copy of parent(s) or legal guardian(s) Photo ID and/or Insurance Card(s)

Photo ID or Insurance Card Copy		Photo ID or Insurance Card Copy
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I/we, as parent(s) or legal guardian(s) of the minor/patient named above, authorize the person(s) listed below to consent to diagnostic evaluation and/or treatment and emergency medical services when I am not able to accompany my child/patient. I/we understand that we can revoke this consent at any time. A facsimile or photocopy of this document will be accepted in lieu of the original. This consent is valid for one year from the signed date of this form.

Names of individual(s) authorized to acquire routine and emergency services for my child/patient:

Full Name	Relationship

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian Signature:	Date:
Witness:	Date:
Witness Printed Name:	Witness Phone:
Witness Street Address:	