

CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD

I (We) _____ and _____
(name) (name)
of _____, do hereby state
(city) (county) (state)
that I am (we are) the parent(s) legal guardian(s) of _____
(name)
a minor, age _____, born _____, who resides with me (us)
(date)
at _____
(street address)
I (We) authorize _____, an adult who resides
(name)
at _____ in the city of _____,
(street address)
county of _____, state of _____, to consent to any necessary
examination, anesthetic, medical diagnosis, surgery or treatment, and / or hospital care to be rendered to
the above-named minor under the general or special supervision and on the advise of any physician or
surgeon licensed to practice medicine in the state(s) of _____
_____. Valid August 1, 20____, thru July 31, 20_____.

PARENT or GUARDIAN (Signature) (Relationship) (Date)

PARENT or GUARDIAN (Signature) (Relationship) (Date)

STATE OF: _____

COUNTY OF: _____

Signed and sworn in my presence, a notary, this ____ day of _____, 20_____.

Notary Public - State of Indiana

My commission expires:_____.

FAMILY DOCTOR: Name: _____ Phone: _____

MEDICAL INSURANCE CARRIER: Company _____

Identification Number _____ Member's Name _____

Benefit Code _____ Account Number _____

MEDICAL HISTORY: Allergies, if any, including medication _____

Tetanus (date of last booster) _____

Chronic or existing diseases or medical problems (diabetes, epilepsy, etc.) _____

Medicines your child is taking now: _____
