# Pediatric Medical Consent Form

This form authorizes medical treatment for a minor child in the absence of a parent or legal guardian.

## Child Information

Full Name

Date of Birth

MM/DD/YYYY

Address

## Parent/Guardian Information

Name

Relationship to Child

Phone Number

Alternate Phone

Address

## Authorized Person Information

Full Name

Relationship to Child

Phone Number

## Medical Information

Allergies

Current Medications

Special Medical Conditions

Primary Care Physician

Physician Phone

Insurance Information

## Consent

I hereby authorize the above-named person to consent to and obtain any medical treatment deemed necessary for my child in my absence.

Printed Name of Parent/Guardian

Signature

Date

MM/DD/YYYY