

Parental Consent Form for Medical Treatment

I, the undersigned parent or legal guardian, hereby authorize medical treatment for my child as deemed necessary by qualified medical personnel.

Child Information

Full Name

Date of Birth

Home Address

Parent/Guardian Information

Full Name

Relationship to Child

Contact Number

Alternative Contact Number

Medical Information

Known Allergies

Current Medications

Relevant Medical Conditions

Primary Physician**Physician Contact Number****Consent**

I hereby give my permission for emergency medical treatment to be administered to my child as deemed necessary. I understand that every effort will be made to contact me prior to treatment.

Parent/Guardian Signature

Date

Printed Name
