Parental Medical Treatment Consent & Waiver

Minor's Full Name:

_____

Date of Birth:

_____

Parent/Guardian Name:

_____

Relationship to Minor:

_____

Contact Number:

_____

Address:

_____

Medical Information (Allergies, Current Medications, etc.):

Consent:

I, the undersigned parent or legal guardian, authorize medical treatment for my minor child as deemed necessary by qualified medical personnel. This consent is given to permit hospital care or emergency medical treatment for my child. I acknowledge that no guarantee has been made as to the results of any treatment.

Signature of Parent/Guardian:

_____

Date:

_____