

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I/We, _____, of _____ (city),
_____ (county), _____ (state), do hereby state that I am the parent or legal guardian
of _____, a minor born
_____, who resides with me at _____ (street
address). I authorize _____ (caregiver name), an adult who
resides at _____, _____, _____ to consent to any and all
necessary examinations, 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 advice of any physician or surgeon licensed to practice medicine in the state of _____.

Date

Signature of Parent or Legal Guardian

Witness Signature

Witness Name (please print)