CHILD MEDICAL CONSENT FORM

Authorization and Treatment

I, _____[NAME OF PARENT], as a parent or authorized representative, hereby appoint _____[NAME OF PROXY/NAME OF MEDICAL PROVIDER], _____[RELATIONSHIP], to consent to and authorize the following treatments for my child(ren):

□ Routine medical care and interventions

This type of treatment may include but is not limited to, medical evaluation, physical exams, X-rays, and lab work.

Other treatments allowed:

□ Immunizations
□ Allergy shots
□ Intramuscular/intravenous antibiotics

□Emergency treatment

I hereby grant the decision-maker appointed above, be it a proxy or a medical provider, permission to consent to and authorize the medical care checked above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth :_____

Limitations

Identify any specific limitations on the kinds of medical services for which this authorization is given.

□ None
□ Limitations described below:

_____
_____
_____.

Parental contact information

_____*[PARENT NAME #1]*, _____*[TELEPHONE NUMBER]*.

_____*[SIGNATURE]*

_____*[DATE OF SIGNATURE]*.