MEDICAL CONSENT
TO TREAT MINOR CHILDREN

PATIENT NAME _____

DATE OF BIRTH _____/_____/_____
mm dd yyyy

I, _____, parent or legal guardian of _____, do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child while said child is under the care of :

Names or caretaker(s)	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

and I am not reasonably available by telephone to give consent. The above-mentioned care taker(s) are authorized to:

- obtain medical treatment and procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians and other appropriate health care providers.
- obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

This temporary authorization shall be effective from _____/_____/_____, and shall remain effective until revoked from the undersigned.
mm dd yyyy

_____ _____
PRINTED NAME OF PARENT/GUARDIAN DATE

_____
SIGNATURE OF PARENT/GUARDIAN