Consent for Medical/Surgical/Emergency treatment for a minor

In presenting my son/daughter for diagnosis and treatment

Name:

Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter ☐

___________________________________ for _______________________________

of _______years of age, herby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized members of Meridian Family Medicine, as may in their professional judgment be necessary.

The following person(s) have permission to bring in___________________________________ and make (Patient/Child's name) medical decisions on my behalf:

1) ____________________________________ Relation: ______________________
2) ____________________________________ Relation: ______________________
3) ____________________________________ Relation: ______________________
4) ____________________________________ Relation: ______________________

I have read this form and certify that I understand its contents.

*Printed name of guardian: ____
*Signature of guardian: ____
*Relationship to patient(s): ____
*Date _____________________