

**CONSENT FOR
MEDICAL TREATMENT OF MINOR**

We, _____ and _____ declare:
(name of person giving consent) (name of person giving consent)

The parents of _____, a minor, age _____ (____), born _____ are
(child's name) (child's age) (child's birth date)
_____ and _____. We, _____ and _____
(father's name) (mother's name) (name of person giving consent) (name of person giving consent)
are _____'s _____
(child's name) (relationship to child of persons giving consent) (managing conservator or guardian's name)
_____ 's managing conservator or guardian (if appointed). In our absence we authorize the
(child's name)
following people to make medical decisions on behalf of _____:
(child's name)

_____	_____
(name of person authorized to consent to child's medical treatment)	(person's relationship to child)
_____	_____
(name of person authorized to consent to child's medical treatment)	(person's relationship to child)
_____	_____
(name of person authorized to consent to child's medical treatment)	(person's relationship to child)
_____	_____
(name of person authorized to consent to child's medical treatment)	(person's relationship to child)

For medical services in the nature of: _____

_____.

Treatment authorized by this consent may begin _____.

Pediatrician is _____ at _____.
Pediatrician's phone number is _____.
Cardiologist is _____ at _____.
Cardiologist's phone number is _____.

Health History: _____

Medications: _____

Known Allergies: _____

_____	_____	_____
(signature of person giving consent)	(printed name of person giving consent)	(date)
_____	_____	_____
(signature of person giving consent)	(printed name of person giving consent)	(date)
_____	_____	_____
(signature of witness)	(printed name of witness)	(date)