



**PARENTAL CONSENT FOR
MEDICAL CARE OF A MINOR**

We (I), _____ and
_____, are (am) the
parent(s) and/or legal guardian(s) of the following named children:

_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

We (I) hereby authorize any one of the following individuals:
_____ of _____
_____ of _____
_____ of _____
_____ of _____

to consent to any and all medical care and attention for these children that is deemed necessary and appropriate by a licensed physician in this state. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care.

We (I) further agree to reimburse the health care provider for the cost of rendering these services. The child(ren) is covered under the following healthcare plan:

The following information is provided to assist in this care:
Name of child: _____
Physician: _____
Allergies: _____
Medications: _____
Handicaps or Illnesses: _____

Signature of Mother
Date _____

Signature of Father
Date _____