



CONSENT FOR EMERGENCY MEDICAL TREATMENT OF A MINOR*

CHILD'S NAME _____ **DATE OF BIRTH** ___/___/___

Social Security Number _____

Address _____

Child's Regular Physician _____ **Phone** _____

Address _____

Health Insurance Company _____ **Phone** _____

Name of Primary Insured _____

Social Security Number (Primary Insured) _____

Health Benefit Plan _____ Customer Service No. _____

Policy Number _____ Certificate No. _____

I, _____, the person having legal custody or legal guardian of the above named child authorize any one of the following adults,

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice, and to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care, to be rendered to the minor by any dentist licensed to practice.

SIGNATURE OF PARENT, PERSON OR LEGAL GUARDIAN

DATE

NOTARY PUBLIC: Acknowledged before me on this date.

DATE

SIGNATURE OF NORARY

STATE _____

MY COMMISSION EXPIRES: _____



***Check with your physician for any special requirements for your state.**

SEAL OF OFFICE