MEDICAL CONSENT (FOR A MINOR)

I, _____, the parent or legal guardian of _____, residing at _____ [Address] born on the ___ day of _____, 20___ do hereby consent and allow _____ [Grandparent] to handle any type of medical care for my child including but not limited to the administration of anesthesia determined by a physician, surgery, and any other care recommended or deemed as necessary for the welfare of my child.

This authorization is effective from on this ___ day of _____, 20___ and expires on the ___ day of _____, 20___

_____	_____	_____
Signature of Parent or Legal Guardian	**Date**	**Print Name**
_____	_____	_____
Signature of Witness	**Date**	**Print Name**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Father's Telephone: _____ Mother's Telephone: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

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