BEACON
HEALTH SYSTEM

CONSENT TO TREAT MINOR CHILD

I _____, parent or legal guardian of _____
(Your Name) (Minor's Name)

___/____/____, do hereby consent to any medical care determined by a physician to be necessary for the
(Minor's DOB)

welfare of my child while said child is under the care of _____.
(Name of Person Bringing in Minor)

This authorization is effective from ____/____/____ to ____/____/____

Parent/Guardian Signature: _____ **Date:** ____/____/____

Witness Signature: _____ **Witness Name:** _____
(Please Print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. A copy of the parent's driver's license and any insurance card(s) - front and back - should accompany this form.

This additional information will assist in treatment if it can be furnished with the consent, but is not required.

Address: _____ **City:** _____ **State:** ___ **ZIP:** _____

Mother's Primary Phone: _____ **Work:** _____

Father's Primary Phone: _____ **Work:** _____

Allergies to Drugs or Foods: _____

_____

Last Tetanus: _____/_____/_____

Special medications, blood type or pertinent information: _____

_____

Child's Physician: _____ **Phone:** _____

Insurance: _____ **Policy #:** _____