BEACON
MEDICAL GROUP

CONSENT TO TREAT MINOR CHILDREN
Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child while said child is under the care of _____.

(Name of person bringing in minor)

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian (a copy of the parent's driver's license is recommended to accompany form)

_____ _____
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.

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

Family address: _____
Street Address City State Zip Code

Telephone: Father: _____ (home/cell) _____ (work)
Mother: _____ (home/cell) _____ (work)

Child's Birthdate: _____ Last Tetanaus _____

Allergies to drugs or foods: _____

_____

Special medications, blood type or pertinent information: _____

_____

_____

Child's Physician: _____ Phone _____

Insurance: _____ Policy #_____

Preferred Hospital _____

A copy of your insurance card(s), front and back, should accompany form.