CONSENT TO TREAT MINOR CHILDREN

Please print all information

Date: ____/____/____

I, _____, parent or legal guardian of

_____, DOB:____/____/____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of

_____ and I am not reasonably available by telephone to provide consent.

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

_____ ____/____/____
Signature of Parent or Legal Guardian

_____ ____/____/____
Witness Signature

_____
Witness Name (please print)

MEDICAL HISTORY OF MINOR

Address: _____

Phone: Mother: ( ) ____-_____Home ( ) _____-_____alt/wk/cell

Father: ( ) ____-_____Home ( ) _____-_____alt/wk/cell

Insurance: _____Policy#:_____GRP#:_____

Preferred Hospital: Lutheran, Parkview, St. Joe, Dupont, Parkview North, Other:_____

Allergies: _____

Date of last Tetanus: ____/____/____

Medications/Pertinent Information: _____

Child's Primary Care Physician: _____

Pediatric Associates, Inc.
7910 W. Jefferson Blvd., Ste. 201
Fort Wayne, IN 46804
(260) 436-3789

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.