Pinnacle Physicians Group

CONSENT TO TREAT MINOR CHILD

(Please print all information)

I, _____, parent or legal guardian of

_____, born _____, 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 give consent.

This authorization is effective from _____ to _____.

_____ _____

Signature of Parent or Legal Guardian Parent or Legal Guardian Name (please print)

_____ _____

Witness Signature Witness Name (please print)

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

Family address _____

Father phone: _____ cell: _____

Mother phone: _____ cell: _____

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____

_____

Special Medications, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____

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