Ohio State University

CONSENT TO TREAT MINOR CHILD

Please print all information

I, _____ (first and last name), the parent or legal guardian of _____ (minor child's first and last name), born on. ____/____/____ 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 _____

_____ _____

Signature of Parent or Legal Guardian Date

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.

Minor Child's Address:

Parent/Legal Guardian's Telephone Number:

Minor Child's Birthdate: Minor Child's Last Tetanus Shot:

Minor Child's Allergies to Food, Drugs or Environmental Factors:

Minor Child's Special Medications, Blood Type or Pertinent Information:

_____

Minor Child's Physician: Physician Phone:

Insurance Carrier: _____ Policy #: _____

Preferred Hospital in the Event of Emergency: _____

_____