CONSENT TO MEDICAL CARE AND TREATMENT

I,____(legal guardian), authorize all medical and surgical treatment, x-ray, laboratory, anesthesia, and other medical/hospital procedures as may be performed or prescribed by a licensed physician for,

____(patient's name) and waive my right to informed consent of treatment.

Birth Date ____

Birthplace ____

Mother's Maiden Name ____________________________________

Allergies ____

Chronic Illnesses ____

Regular Medications ______________________________________

Date of Last Tetanus Immunization __________________________

Patient's Physician _______________________________________

Physician's Phone Number __________________________________

Mother's Emergency Contact Number _________________________

Father's Emergency Contact Number _________________________

________________________________ ________________________________
Date Signature of Legal Guardian

________________________________ ________________________________
Witness Patient's Address