Child Medical Treatment Consent Form

Child Information

Child's Full Name:

Date of Birth:

Parent/Guardian Name:

Relationship to Child:

Medical Information

Family Physician:

Allergies/Medical Conditions:

Current Medications:

Consent Statement

I hereby authorize any licensed physician, medical practitioner, hospital, or other healthcare provider to provide any necessary medical treatment for my child listed above in case of emergency or when I cannot be reached.

Parent/Guardian Signature:

Date:

Submit