

MINOR MEDICAL CONSENT FORM

1. Parent / Legal Guardian Information

Full Name: _____

Address: _____

City/State/Zip: _____

Phone (Primary): _____

Phone (Secondary): _____

Email: _____

Relationship to Minor: Parent Legal Guardian Other: _____

2. Minor Information

Full Name: _____

Date of Birth: _____

Gender: _____

Address (if different from above): _____

Allergies (medications/food/other): _____

Current Medications: _____

Medical Conditions: _____

Primary Care Physician: _____

Physician Phone: _____

Health Insurance Provider: _____

Policy Number: _____

Group Number: _____

3. Authorized Caregiver (Person Receiving Consent)

Full Name: _____

Relationship to Minor: _____

Phone: _____

Address: _____

4. Medical Authorization

I, _____ (parent/legal guardian), authorize the above-named caregiver to consent to any medical treatment deemed necessary for my minor child listed above.

This authorization includes, but is not limited to:

- Emergency medical treatment
- Hospitalization
- Surgery
- X-rays
- Routine medical care
- Dental treatment
- Prescription medications

This consent is effective from _____ (start date) and will remain in effect until _____ (end date), unless revoked in writing.

5. Emergency Contacts (Other Than Parent/Guardian)

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

6. Signature

I certify that I am the parent or legal guardian of the above-named minor and that I have the legal authority to grant this consent.

Parent/Guardian Signature: _____
Printed Name: _____
Date: _____

NOTARY ACKNOWLEDGMENT (Recommended)

State of _____

County of _____

The foregoing instrument was acknowledged before me this ____ day of _____, 20____ by _____, who is personally known to me or who has produced _____ as identification.

Notary Signature: _____

Printed Name: _____

Commission Number: _____

My Commission Expires: _____