Christian Community Child Center
Medical Treatments Consent for Minors

Dear Parents/Guardian:

This card should be presented to the attending physician if your child is in need of medical treatment during your absence.

This card will prevent delay of treatment for your child because of lack of proper authorization. I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child

_____

(Child name)

in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing medical procedures acting on the authority of this medical Treatment Consent Form which are deemed necessary for my minor child.

_____

(Signature of Parent/Legal Guardian Date)

Please fill out both sides of this form!

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(Signature of Parent/Legal Guardian Date)

Please fill out both sides of this form!

Childs Name_____ Birthdate_____

Address: _____

Father's Name_____ Employer:_____

Home Phone: _____ Employer Number_____ Cell Phone_____

Mother's Name_____ Employer:_____

Home Phone_____ Employer Number_____ Cell Phone_____

Child's Physician: _____ Family Physician_____

Child is Allergic To: _____

Medical Information (included last Tetanus Shot, major illness): _____

_____

Insurance Company and Policy Number_____

Responsible Party: _____

Childs Name_____ Birthdate_____

Address: _____

Father's Name_____ Employer:_____

Home Phone: _____ Employer Number_____ Cell Phone_____

Mother's Name_____ Employer:_____

Home Phone_____ Employer Number_____ Cell Phone_____

Child's Physician: _____ Family Physician_____

Child is Allergic To: _____

Medical Information (included last Tetanus Shot, major illness): _____

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Insurance Company and Policy Number_____

Responsible Party: _____