Medical Consent Form for Child

Patient Name

Date of Birth

Address

City **State** **Zip**

Cell Phone: Primary

I,_____ , the parent or legal guardian of , born , do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child when accompanied and supervised by the listed persons:

Authorized Caregiver NAME

Relationship to Patient

Authorized Caregiver NAME

Relationship to Patient

Authorized Caregiver NAME

Relationship to Patient

Authorized Caregiver NAME

Relationship to Patient

Parent/Guardian Signature

Date