

Consent to Treat Form

As parent or legal guardian (circle one) for _____, I give
Permission for the persons listed below to authorize any medical treatment my child may need, in the
event I am not able to accompany my child.

Names	Date of Birth	Relationship to Child
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

Signature of Parent or Guardian

Date

