Consent to Treat a Minor

Names of Minors	Birthdates

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:
sponsor, teacher, minister, etc.

Name	Address	Phone

To act in my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence.
from ______________________________ to ________________________________.

Please record any allergies or current health conditions requiring medical treatment, medications, or special restrictions.

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This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, surgical care, or hospitalization may be required.

Parent/Guardian

Name			Signature	
Address				
City	State	Zip	Phone	Date

Hospitalization for the above named minor(s).

Name of Insurance Company	Identification Number

Family Physician

Name	Phone