CONSENT FOR CHILD(REN) MEDICAL TREATMENT

________________________________ ____________________________
CHILD DATE OF BIRTH

________________________________ ____________________________
CHILD DATE OF BIRTH

________________________________ ____________________________
CHILD DATE OF BIRTH

This letter gives my/our consent to:____
NAME OF PERSON AND RELATION TO PATIENT

Who will be caring for my/our above-captioned child(ren) for the following date(s) _______________________________.

to arrange for routine or emergency medical care and treatments necessary to preserve the

health of my/our child(ren)

By signing below, I/We acknowledge that I am (we are) responsible for all reasonable charges in connection with the care and treatment rendered during this period.

GUARDIAN INFORMATION:

__________________________________ __________________________________
NAME RELATION TO PATIENT

____
ADDRESS

____
PHONE NUMBER

____
SIGNATURE

____
DATE