SELINA SHAH
Dance & Sports Medicine

BASS
MEDICAL GROUP

CONSENT TO TREAT MINOR CHILDREN IF PARENT NOT PRESENT

Please print all information

I, ________________________________, 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 while said child is under the care of _________________________ and I am not reasonably available by telephone to give consent.

This authorization is effective from __________________________ to _________________________________.

____
Signature of Parent or Legal Guardian Date

____ ____
Witness Signature Date Witness Name (please print)

Telephone: Father: ____________________ home/cell ____________________ work

Mother: ____________________home/cell ____________________ work

Last Tetanus: ____________________

Allergies to drugs or foods: ____

____

Special Medications, Blood Type, or Pertinent Information:

____

____

Child's Physician: ____ Phone: ____________________

Preferred Hospital: ____

Insurance: ____ **(Please send insurance card with minor)**

This consent form should be brought with the child to the physician's office or CLINIC where the child is taken for treatment.