



## Consent To Provide Medical Care For A Minor

By signing this form, I hereby authorize \_\_\_\_\_ to provide only and all medical treatment for \_\_\_\_\_ (child) that is recommended by a licensed health care provider to whom the Child is presented for treatment.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Child's Social Security Number

Any special medications/allergies or other pertinent information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Date of Service

I hereby authorize the above mentioned physician to administer treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the physician/guardian to summon any and all professional emergency personnel to attend, transport, and treat the child. In addition, I hereby issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state of Montana in which such treatment is to occur.

Signature of patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent contact: \_\_\_\_\_

Emergency contact: \_\_\_\_\_