performancehealth

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care and/or chiropractic determined by a physician to be necessary for the welfare of my child while said child is under the care of the Performance Health staff .

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian_____

Witness Signature /Witness Name _____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address _____

Telephone: Father _____ home _____ work

Mother _____ home _____ work

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____

_____

Special Medications, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____