PRIORITY MEDICAL ASSOCIATES

MEDICAL CONSENT TO TREAT A MINOR

Child's Name (Full Legal Name): _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Parent(s) Legal Guardian(s) Name: _____

Address:

_____

_____

_____

Home Phone # _____ **Work Phone #** _____

Cell Phone # _____

Additional Contact Information:

_____

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I hereby grant my authorization and consent for _____ to be treated by Priority Medical Associates. I hereby authorize Dr. _____, and whomever he may designate as his assistant or associate physicians to administer treatment as he so deems necessary to my _____.

This authorization is effective commencing on the ____ day of _____, 20___.

Parent's Signature:_____

Legal Guardian's Signature:_____