NORTH TEXAS FAMILY MEDICINE

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD

I, (we) _____ of _____
(city)

_____ County, _____, do hereby state that I am (we are)
(county) (State)

the natural parent (s) having legal custody of _____
(Child's name)

a minor, age _____, born _____, who resides with me (us) at
(age) (Date)

_____.
(Address)

I authorize _____, an adult, who resides
(Name)

at _____ in the city of _____,
(address) (City)

county of _____, state of _____, to consent to
(County) (State)

any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician licensed to practice in the state of Texas, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

Date this _____ day of _____, (year) _____

_____
(signature)

Child's allergies, if any_____

Medicines child is taking_____

Starting Date_____

Expiration Date_____