Crockett Medical Clinic

CONTACT INFORMATION

5/31/2016

Patient Name _____ DOB _____

EMERGENCY CONTACT: This is someone that will only be contacted in an Emergency situation.

Name _____ Relationship _____ Phone Number_____
Name _____ Relationship_____ Phone Number _____

MEDICAL RELEASE INFORMATION: This is someone we can give any of your medical information

Name _____ Relationship _____ Phone Number _____
Name _____ Relationship _____ Phone Number _____
Name _____ Relationship _____ Phone Number _____

Signature _____ **Date** _____

MINOR TREATMENT CONSENT COMPLETE BELOW FOR CHILDREN UNDER 18

Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable
The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, when I am not immediately available in person. It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child with the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print)

Name_____ Relationship to Child _____ Phone _____

Name _____Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

Medical concerns: _____

Known Allergies: _____

Name of Parent or Legal Guardian_____ Contact Number _____

Address _____

Signature _____ Date _____
This Consent is effective until withdrawn in writing by the child's parent or guardian.