Crockett Medical Clinic

CONTACT INFORMATION; MINOR TREATMENT CONSENT

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** _______________

ONLY COMPLETE 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This Consent is effective until withdrawn in writing by the child's parent or guardian.