**Medical Consent - Minor**

CONSENT TO TREAT MINOR CHILD:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born

the \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of First Baptist Church of DeFuniak Springs, City of DeFuniak Springs, State of Florida, and I am not reasonably available by telephone to give consent.

This authorization is effective from the \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ to \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ (not to exceed one year).

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian)

Parent/Guardian’s phone number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Witness)

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. The additional information below may assist in treatment if needed. It can be furnished with the consent but it is not required. Parent/Guardian is responsible for updating the church if any changes should occur.

Family Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ father, mother, grandparent, guardian, other (circle one)

Alternate Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ father, mother, grandparent, guardian, other (circle one)

Last Tetanus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to drugs or foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Medications, Blood Type or Pertinent Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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