College Park Family Care Center

PERMISSION FOR MEDICAL TREATMENT

In the event of our absence or unavailability, _____
Name of Individual(s)

_____

is authorized to give consent for the medical treatment of our minor child/children:
(list names and ages of each)

_____

_____

_____

We realize that our child/children might be in need of immediate medical treatment to relieve pain or to begin the healing processes even though his/her life might not be in danger.

This consent is specifically given to cover the period from _____ to _____, during which we may be unavailable to consent to treatment of our minor child/children.

_____ _____ _____
Date Signed Father Mother

_____ _____
Physician Preferred Parents' Home Address

_____ _____
Hospital Preferred Phone Number

_____ _____ _____
Last Tetanus Toxoid Health Insurance Company Policy Number

Drug allergies or medications pertaining to each child: