Medical Consent by Parent or Legal Guardian of Minor Child or Children

I, _____being the parent or legal guardian having legal custody of the minor child or children named below, authorize the performance of all medical, surgical, diagnostic, and hospital care, procedures or treatment, which may be performed or prescribed for the minor child or children by a licensed physician or hospital, when reasonable efforts to timely contact me are unsuccessful and when such care or procedures are deemed immediately necessary or advisable by the physician to safeguard the minor child's or children's health. I hereby waive my right of informed consent to such care, procedures, or treatment for:

Minor Child's or Children's Complete Name(s):

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Name of Minor Child's or Children's Physician: _____

Physician's Telephone: (_____) _____

CUSTODIAL PARENT OR LEGAL GUARDIAN: **CIRCLE ONE**: Parent/Legal Guardian Signature

_____ X_____

(Print Name) (Signature)

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

EMERGENCY CONTACT PERSON:

_____ Home Phone (____) _____ Work Phone (____) _____

(Print Name)