CONSENT FOR MEDICAL TREATMENT OF A MINOR

Patient Name: _____(minor)

DOB: _____ *Age: _____*

NAME OF ADULT(S) *RELATIONSHIP*

_____ _____

_____ _____

I hereby authorize the above named minor and/or the above person(s) adult(s) (into whose care the minor has been entrusted) to consent to any necessary outpatient medical and/or surgical diagnosis or treatment, laboratory testing, anesthesia or x-ray examination as deemed advisable by a licensed physician and provided by that physician or healthcare worker under the physician's supervision, regardless of where the treatment is provided.

I hereby authorize the above named minor (without my physical presence) to consent to any necessary outpatient medical and/or surgical diagnosis or treatment, laboratory testing, anesthesia or x-ray examination as deemed advisable by a licensed physician and provided by that physician or healthcare worker under the physician's supervision, regardless of where the treatment is provided.

I understand and agree that the signature and date on this form will not expire without written notice or in the case that a minor becomes an adult. A photocopy of this form is considered as valid as the original.

This authorization is made under Family Code §6910.

Signed:_____DATE:_____
(Parent, Guardian)

Print Name:_____Relationship_____

( ) Parent with legal custody

( ) Guardian with legal custody