

# NORTH PERRY PEE WEES CONSENT FOR MEDICAL CARE AND TREATMENT

I, \_\_\_\_\_, THE PARENT/LEGAL GUARDIAN OF \_\_\_\_\_ AUTHORIZE AND CONSENT TO MEDICAL, SURGICAL AND HOSPITAL CARE, TREATMENT AND PROCEDURES TO BE PERFORMED FOR MY CHILD BY A LICENSED PHYSICIAN OR HOSPITAL WHEN DEEMED NECESSARY OR ADVISABLE BY THE PHYSICIAN TO SAFEGUARD MY CHILD'S HEALTH AND I CANNOT BE CONTACTED. I WAIVE MY RIGHT OF INFORMED CONSENT TO SUCH TREATMENT.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

ADDRESS		HOME PHONE		CELL PHONE
FATHER'S NAME	WORK PHONE	MOTHER'S NAME	WORK PHONE	
CHILD'S BIRTHDATE	AGE	NAME OF LOCAL FRIEND OR RELATIVE AND PHONE NUMBER		
HEALTH INSURANCE COMPANY		ALLERGIES?	MEDICATIONS?	
PHYSICIANS NAME AND PHONE NUMBER				

# NORTH PERRY PEE WEES CONSENT FOR MEDICAL CARE AND TREATMENT

I, \_\_\_\_\_, THE PARENT/LEGAL GUARDIAN OF \_\_\_\_\_ AUTHORIZE AND CONSENT TO MEDICAL, SURGICAL AND HOSPITAL CARE, TREATMENT AND PROCEDURES TO BE PERFORMED FOR MY CHILD BY A LICENSED PHYSICIAN OR HOSPITAL WHEN DEEMED NECESSARY OR ADVISABLE BY THE PHYSICIAN TO SAFEGUARD MY CHILD'S HEALTH AND I CANNOT BE CONTACTED. I WAIVE MY RIGHT OF INFORMED CONSENT TO SUCH TREATMENT.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

ADDRESS		HOME PHONE		CELL PHONE
FATHER'S NAME	WORK PHONE	MOTHER'S NAME	WORK PHONE	
CHILD'S BIRTHDATE	AGE	NAME OF LOCAL FRIEND OR RELATIVE AND PHONE NUMBER		
HEALTH INSURANCE COMPANY		ALLERGIES?	MEDICATIONS?	
PHYSICIANS NAME AND PHONE NUMBER				

# NORTH PERRY PEE WEES CONSENT FOR MEDICAL CARE AND TREATMENT

I, \_\_\_\_\_, THE PARENT/LEGAL GUARDIAN OF \_\_\_\_\_ AUTHORIZE AND CONSENT TO MEDICAL, SURGICAL AND HOSPITAL CARE, TREATMENT AND PROCEDURES TO BE PERFORMED FOR MY CHILD BY A LICENSED PHYSICIAN OR HOSPITAL WHEN DEEMED NECESSARY OR ADVISABLE BY THE PHYSICIAN TO SAFEGUARD MY CHILD'S HEALTH AND I CANNOT BE CONTACTED. I WAIVE MY RIGHT OF INFORMED CONSENT TO SUCH TREATMENT.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

ADDRESS		HOME PHONE		CELL PHONE
FATHER'S NAME	WORK PHONE	MOTHER'S NAME	WORK PHONE	
CHILD'S BIRTHDATE	AGE	NAME OF LOCAL FRIEND OR RELATIVE AND PHONE NUMBER		
HEALTH INSURANCE COMPANY		ALLERGIES?	MEDICATIONS?	
PHYSICIANS NAME AND PHONE NUMBER				