

# 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								

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