Consent for Medical Treatment of a Minor Child

In the Absence of a Parent or Guardian

I/We ____ and ____
(NAME) *(NAME)*
of ____
(CITY, COUNTY, STATE)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of

____, a minor age ____________, born _____________________,
(NAME) *(DATE)*

who resides with me (us) at ____
(STREET ADDRESS)

In my absence, I (We), authorize the following adults____

____.
(NAMES)

to consent to any necessary examination, anesthetic, medical diagnosis, or treatment to be rendered at EZCARE Walk-In Medical Center to the above-named minor under the general or special supervision and on the advice of any physician or nurse practitioner licensed to practice medicine in the state of______________.

Dated this ________ day of_______________________, 20______.

_____________________________________ _____________________________________
(SIGNATURE OF PARENT OR GUARDIAN) *(SIGNATURE OF PARENT OR GUARDIAN)*

_____________________________________ _____________________________________
(WITNESS SIGNATURE) *(DATE)*

_____________________________________ _____________________________________
(WITNESS NAME PRINTED) *(WITNESS ADDRESS)*