PRIMARY CARE ASSOCIATES of Appleton, LTD

Medical Treatment Consent for Minors

Dear Parent or Guardian:

This card should be presented to the attending physician if your child is in need of medical treatment during your absence. Have each of your minor children (through age 18) carry a card with them or have it available when you are absent. This card will prevent delay of treatment for your child because of lack of proper authorization. Individual hospitals or physician offices may require additional authorization.

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child:

(Name) _____

in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital or physician's office(s), as well as any physician office, medical authorities, and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary to my minor child.

_____

Signature of Parent or Legal Guardian Date

_____

Witness

Medical Treatment Consent for Minors

Child's Name: _____ Date of Birth: _____
Address: _____

Father's Name: _____
Father's Home Phone: _____Mobile Phone: _____
Father's Employer: _____ Work Phone: _____

Mother's Name: _____
Mother's Home Phone: _____Mobile Phone: _____
Mother's Employer: _____ Work Phone: _____

IF PARENTS ARE NOT AVAILABLE IN AN EMERGENCY, CONTACT:
Name: _____ Phone Number: _____
Address: _____
Relationship to Child: _____

Child's Family Doctor: _____
Child is Allergic To: _____
Medical Information (including last Tetanus shot, major illness, etc.:)

_____

_____

_____

Insurance Company Name: _____
Subscriber/Policyholder ID: _____ Group #:_____