Consent to Treat Form

As parent or legal guardian (circle one) for _____, I give permission for the persons listed below to authorize any medical treatment my child may need, in the event I am not able to accompany my child.

Names	Date of Birth	Relationship to Child
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____

_____ _____

Signature of parent or guardian Date