Medical Consent Form

I, _____, am a [Parent/Legal Guardian] of _____, born on _____, do hereby consent to the following medical care while said individual is under the care of _____ of _____, City of _____, State of _____:

- ❑ X-ray examination;
- ❑ Anesthetic;
- ❑ Medical, surgical or dental diagnosis or treatment;
- ❑ Hospital care;
- ❑ Other: _____.

_____	_____	_____
Hospital Insurance (if applicable)	Policy Number (if applicable)	Insurance Company (if applicable)

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered. Should it be necessary for the undersigned to return home, the undersigned shall assume all transportation costs.

This authorization is effective from _____, to _____.

_____	_____
Name of Parent/Legal Guardian	Witness Name
_____	_____
Signature of Parent/Legal Guardian	Witness Signature
_____	_____
Date	Date