MEMPHIS CHILDREN'S CLINIC, PLLC

Consent to Treatment of a Child by Authorized Persons

The undersigned parent or legal guardian of _____
(Child's Name)
authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, ex-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name:_____ Relationship to Child:_____ Phone:_____

   Name:_____ Relationship to Child:_____ Phone:_____

   Name:_____ Relationship to Child:_____ Phone:_____

2. Medical Concerns: _____

3. Known Allergies: _____

Name of Parent or Legal Guardian: _____ Relationship to Child:_____
(Print Name)

Contact Number(s):_____

Address: _____ City, State, Zip:_____

Signature:_____ Date:_____

This consent is effective until withdrawn in writing by the child's parent or guardian.

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