Consent For
Medical Care and Services to a
Minor Child

In presenting my son/daughter for diagnosis and treatment

Name:_____for_____
__Mother ___Father ___Legal Guardian ___son ___daughter

Of_____years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, minor surgical procedure, medical care and treatment by authorized staff and physicians at Broadway Medical Clinic or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to: _____
Name of person caring for the minor child

Who will be caring for our (my) child_____
Name of the child DOB

For the period_____to_____to arrange routine or urgent medical care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment for the rendering period.

Name:_____ Pediatrician_____

Address:_____

Phone #s:_____ _____ Child Allergeies, if any:_____

Insurance name:_____Subscriber name:_____

Subscriber #_____Group #:_____

Signature:_____Date_____
Mother, Father, or Legal Guardian

In case of emergency, I can be reached at:_____

_____