Consent For Medical Care and Services to a Minor Child

_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 __to arrange routine or urgent to_____ For the period 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. Pediatrician Address: Phone #s:_____ Child Allergeies, if any:_____ Insurance name: _____Subscriber name: _____
 Subscriber #_______
 Group #:_______
 ______Date_____ Signature:___ Mother, Father, or Legal Guardian In case of emergency, I can be reached at:______