
(LAST NAME) (minor child)

(FIRST NAME)

CONSENT TO MEDICAL TREATMENT

I, _____, the (parent) (guardian) of _____,
a minor child whose birth date was _____, 19____ and who is the child of _____
and _____ hereby authorizes any duly authorized doctor, hospital or other medical
facility to treat said minor on or after _____20____ for the purpose of attempting to treat or
relieve any injuries received by said minor while he was a participant or observer at _____

I authorized any licensed physician to perform any procedure which he deems advisable in attempting to treat or relieve
any injuries or any related unhealthy condition of said minor that he may encounter during any necessary operation.

I consent to the administration of anesthesia as deemed advisable by any licensed physician.

I realize and appreciate that there is a possibility of complications and unforeseen circumstances in any medical
treatment and I assume any such risk on the behalf of myself and said minor. I acknowledge that no warranty is
being made as to the result of any treatment.

(NAME)

(RELATIONSHIP TO MINOR)

STATE OF _____ §

COUNTY OF _____ §

BEFORE ME, a Notary Public in and for said County and State, personally appeared _____
_____ who acknowledged that he has read the above and forgoing instruments and
that the execution of both was his voluntary act and deed and that all statements therein are true and correct.

Witness my hand and seal this _____ day of _____, 20_____.

Notary Public and for

_____ County, _____

My Commission Expires _____