SCENT
ALLERGY & SLEEP MEDICINE

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born

_____do hereby consent to any medical care and treatment determined by a physician to be

necessary for the welfare of my child while said child is under the care of _____ (adult

with child) of _____ (street address), City of _____ State of _____.

Select One:

☐ This authorization is effective from: _____ to _____.

☐ This authorization is effective from the date signed below until revoked in writing.

I hereby acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period.

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Witness Signature Witness Name (please print)

Patient Address _____

Parent/Legal Guardian Telephone Number(s): _____

Allergies to drugs or foods: _____

Child's Physician: _____ Phone: _____