98 Terra Mango Loop
Suite 12
Orlando, FL 32835
(407) 612-4007

CONSENT FOR MEDICAL TREATMENT FOR MINOR CHILD WITH TEMPORARY GUARDIAN

Child's Information

Child's Full Name: ________________________________

Address: ____

Date of Birth: ____________ Age: ___________________

Medical Care and Insurance Information

Physician/Pediatrician: _______________________________

Phone Number: _____________________________________

Preferred Medical Facility: ___________________________

Insurance Company: ____________________________

Policy/Group Number: _______________________________

Policy Holder: ______________________________________

Health Information

Health Conditions (e.g. Asthma, Diabetes):
____

Allergies (e.g. to Medications, Food):
____

Prescription Medications: _____________________________

Immunization Status: __________________

I give permission for my child ___________________ to be examined and treated at Advanced Kids Care for the year: _______.

I authorize:
______________________________________ [Name]
______________________________________ [Relationship]
______________________________________ [Address]
______________________________________ [Email]
______________________________________ [Cell]

I also authorize:
______________________________________ [Name]
______________________________________ [Relationship]
______________________________________ [Address]
______________________________________ [Email]
______________________________________ [Cell]

to make medical decisions, consent for an x-ray, diagnostic testing, minor laceration repairs, and medications, and/or administering of any IV treatments and other care that the medical professionals at Advanced Kids Care deem necessary for treatment. I also authorize them to sign any required documents on my behalf for patient registration and billing. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

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.

Signature: ____ **Date**: ______________________________
Mother, Father or Legal Guardian

In case of emergency I can be reached at: **Email**: _______________________ **Cell/Home** :_________________________

Address: ____

Witness to consent: ______________________________________ ____
Print *Signature*

Witness to consent: ______________________________________ ____
Cell number *Email address*

<u>A COPY OF A VALID PHOTO ID MUST BE ATTACHED TO THE COMPLETED FORM!</u>

For office Use Only:

Guardian driver's license verified and scanned by ____ Date: _____________