

\_\_\_\_\_  
(LAST NAME) (minor child)

\_\_\_\_\_  
(FIRST NAME)

**CONSENT TO MEDICAL TREATMENT**

I, \_\_\_\_\_, the (parent) (guardian) of \_\_\_\_\_,  
a minor child whose birth date was \_\_\_\_\_, \_\_\_\_\_ 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 \_\_\_\_\_  
\_\_\_\_\_ 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 results 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 foregoing 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 \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public in and for

\_\_\_\_\_  
County, \_\_\_\_\_

My Commission Expires: \_\_\_\_\_