

# Medical Consent Form

I, \_\_\_\_\_, am a [Parent/Legal Guardian] of \_\_\_\_\_,  
born on \_\_\_\_\_, do hereby consent to the following medical care while  
said individual is under the care of \_\_\_\_\_ of \_\_\_\_\_,  
City of \_\_\_\_\_, State of \_\_\_\_\_:

- ☐ X-ray examination;
- ☐ Anesthetic;
- ☐ Medical, surgical or dental diagnosis or treatment;
- ☐ Hospital care;
- ☐ Other: \_\_\_\_\_.

\_\_\_\_\_  
Hospital Insurance  
(if applicable)

\_\_\_\_\_  
Policy Number  
(if applicable)

\_\_\_\_\_  
Insurance Company  
(if applicable)

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered. Should it be necessary for the undersigned to return home, the undersigned shall assume all transportation costs.

This authorization is effective from \_\_\_\_\_, to \_\_\_\_\_.

\_\_\_\_\_  
Name of Parent/Legal Guardian

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date