

Medical Treatment Parent Consent Form

Child Information

Full Name Date of Birth Allergies / Medical Conditions

Parent / Guardian Information

Full Name Relationship to Child Phone Number
 Alternate Phone Email Address

Emergency Contact

Name Relationship Phone Number

Consent

☐ I hereby give permission for medical treatment of my child as deemed necessary by medical professionals. I also authorize the release of relevant medical information in the event of an emergency.

Parent/Guardian Signature Date