## **Legal Guardianship Consent for Medical Treatment**

Guardian Name
Guardian Address
Guardian Phone Number
Relationship to Minor
Minor's Full Name
Minor's Date of Birth
Medical Treatment to be Consented
Additional Information or Instructions
I, the undersigned legal guardian, hereby grant consent for the above-named minor to receive the medical treatment(s) described above from the designated medical professional or facility.
treathent(s) described above from the designated medical professional or facility.
Guardian Signature

Date