Surgical Procedure Consent for Minor Patient

Patient Information

Minor's Name

Date of Birth

Patient ID/Number

Parent/Guardian Information

Parent/Guardian Name

Relationship to Patient

Contact Number

Procedure Details

Proposed Surgical Procedure

Name of Physician/Surgeon

Description of Procedure

Risks and Potential Complications Discussed

Alternative Treatments Discussed

Anesthesia Type

Consent

I, the undersigned, confirm that I have read and understood the information provided above and consent to the proposed surgical procedure for the minor patient named above.

Parent/Guardian Signature

Date

Physician/Surgeon Signature

Date