Parent/ Guardian Consent for Medical Treatment

Treatment Consent • OC Children's Medical Group

Child(ren) Information

Full Name (First, Middle, Last):	Date of Birth:	Gender:
1.		
2.		
3.		

Caregiver(s) Information

Full Name:	Relationship to patient:
Cell Phone:	Home Phone:

Full Name:	Relationship to patient:
Cell Phone:	Home Phone:

Full Name:	Relationship to patient:
Cell Phone:	Home Phone:

Consent for Treatment

This consent serves as permission for treatment by Orange County Children's Medical group. The above named person(s) shall be authorized to bring my child(ren) to medical appointments and make medical decisions for my child in my absence. I understand that I must still pay for all services provided to my child in my absence.

Please contact me at the following telephone number(s) if you need any further authorizations:

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Print name: ____________________ Relationship: ____________________

Signature: ____________________ Date: ____________________

Witness: ____________________ Witness Signature: ____________________