Ashley Clinic, LLC
Consent to Medical Care for a Minor

____ ________________________

(Print Child’s Name) (Child’s Date of Birth)

By completing this Consent to Medical Care form, you are confirming your authority to delegate the power to consent. Furthermore, you are authorizing the person(s) named in the form to consent for treatment of your child in your absence. The person(s) you authorize may be a babysitter, neighbor, grandparent or any other responsible adult you trust, who is (are) available to obtain medical treatment for your child in your absence.

A separate form must be completed for each child.

I understand that this form will remain valid until I notify the clinic in writing if I want to change or revoke this consent. If there is a change in custody of my child, I will notify the clinic in writing before the next visit.

A medical history section is included in this form. While it is not required to validate this form, it would be useful to medical personnel as they provide care for your child in your absence. Of course, if your child's injury or illness is a medical emergency, medical personnel are authorized by law to provide treatment even if you or the individual(s) named in this form are not available.

By signing this form, I (we) hereby authorize

____

to consent to any medical care and treatment for

____

(Print child’s name)

that is recommended by a licensed healthcare provider to whom the Child is presented for treatment. Any exceptions or limitations may include:

____

In order to ensure that the Child receives prompt medical care and treatment when necessary, I (we) hereby release any licensed health care provider providing medical care to the Child in reliance of this form from liability relating to such provider's acceptance of my (our) substitute care giver's consent.

____ ____________

Signature of Parent, Guardian, or Authorized Representative Date

____ ____________
Signature of Parent, Guardian, or Authorized Representative Date
(Second signature optional)

Emergency Contact Number(s):

____

____

(Please complete the medical history section on the next page)

MEDICAL HISTORY
(Failure to complete any of the following does not impair the validity of this form for consent to medical care for a minor.)

__________________________________ ____________________

(Print Child's Name) (Child's Date of Birth)

Allergies:

____

Immunizations:

____

Previous Hospitalizations and Major Illnesses:

____

Current Medications:

____

Physician (include telephone number):

____

Other important information:

____

OTHER INFORMATION

Father's Full Name:

____

Father's Address:

____

Father's Home Phone #:

____

Father’s Place of Employment:

____

Father’s Work Phone #:

____

Father’s Insurance Company and Policy #:

____

Mother’s Full Name:

____

Mother’s Address:

____

Mother’s Home Phone #:

____

Mother’s Place of Employment:

____

Mother’s Work Phone #:

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Mother’s Insurance Company and Policy #:

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