The Toledo Clinic

The Toledo Clinic
Accompanied Minor Medical Treatment
Authorization and Consent Form

I the undersigned legal guardian/parent of said minor do hereby authorize –

_____

to be the designated substitute adult to accompany said minor for the treatment and services provided or deemed necessary today by (provider) _____.

at (location)_____

These services may include any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and care for the said minor which is advisable by and to be rendered under the general or special supervision of the physician and/or surgeon.

_____

Minor's Full Name

_____

Minor's Address

_____

City, State, Zip Code

_____ _____

Minor's Age *Minor's Date of Birth*

_____ _____

Legal Parent or Guardian Signature *Date*

_____

Legal Parent or Guardian Name (please print)

_____

Address Parent or Guardian

_____

Home Phone *Work Phone* *Cell Phone* *of Parent or Guardian*

_____ _____

Witness Signature *Witness Printed Name*