Frankford Avenue Family Practice, P.C.
8846 Frankford Avenue
Philadelphia, PA 19136
Telephone: *215-322-8221* Fax: *215-332-2979*

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available by telephone to give consent.

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian

_____ _____

Witness Signature Witness Name (please print)

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address _____

Telephone: Father _____ home _____ work

Mother _____ home _____ work

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____

_____

Special Medications, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.