Northwest Civil War Council

Medical Consent by Parent or Legal Guardian of Minor Child or Children

I, ____being the parent or legal guardian having legal custody of the minor child or children named below, authorize the performance of all medical, surgical, diagnostic, and hospital care, procedures or treatment, which may be performed or prescribed for the minor child or children by a licensed physician or hospital, when reasonable efforts to timely contact me are unsuccessful and when such care or procedures are deemed immediately necessary or advisable by the physician to safeguard the minor child's or children's health. I hereby waive my right of informed consent to such care, procedures or treatment for:

Minor Child's or Children's Complete Name(s):

____ Date of Birth:______________________

____ Date of Birth:______________________

____ Date of Birth:______________________

____ Date of Birth:______________________

Name of Minor Child's or Children's Physician:_____________________________________

Physician's Telephone: (_____)____

Signature(s) of Custodial Parent(s) or Legal Guardian:

X____ Home Phone (____)________________
Circle One: Parent/Legal Guardian

X____ Work Phone (____)_________________
Print Name

Cell Phone (____)__________________

X____ Home Phone (____)________________
Second Parent

X____ Work Phone (____)_________________
Print Name

Cell Phone (____)__________________

Alternate Emergency Contact Person:

____ Home Phone (____)________________

Work Phone (____)_________________

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