Olentangy Pediatrics, Inc.

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Authorization for Consent to Medical Treatment of Minor Child

I/we hereby authorize ____ to give consent for all medical and/or surgical treatment that may be required for my child during my absence.

Child's Full Name ____

Date of birth ____________________________

Child's Physician: ____

Child's Allergies ____

Medications child is taking: ____

Important medical history ____

Home address of parent/guardian: _______________________________

____

Parent/guardian Telephone # : ____________________ Cell # ______________________

Signature of legal parent/guardian(s)

____

Date signed ______________________

Signature of adult witness ____

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