



CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of _____ a duly licensed physician or non-physician practitioner, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician or non-physician practitioner in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

Parent or Legal Guardian Signature

Date