974 West Foothill Blvd
Upland Ca, 91786
Tel: 909-981-CARE (2273)
Fax: 909-985-2 FAX (2329)
www.AdvancedCareNow.com

Parental Consent for Medical Treatment

Child's Information

Name: _____DOB:_____

Address:_____

Home#_____

Parent Information

Name:_____

Address:_____

where parents can be reached:_____

Caregiver Information

Name:_____

Address:_____

where caregiver can be reached: _____

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, mental health services, etc.) for the above named child, which may be required during my absence.

This consent serves as permission for treatment by Advanced Medical and Urgent Care Center and its affiliated providers or medical personnel.

I agree to pay for all services provided to my child in my absence.

This authorization shall be effective until:_____, unless earlier revoked by me.

(DATE)

_____ _____

Parent Signature Date

_____

Parent Printed Name