

MINOR CHILDREN MEDICAL TREATMENT CONSENT FORM

NAME _____ DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

CITY/STATE/ZIP _____

MEDICAL HISTORY _____

DRUG ALLERGIES _____ LAST TETANUS SHOT _____

CURRENT MEDICATIONS _____

FATHER'S NAME _____ EMPLOYER _____

EMPLOYER'S MAILING ADDRESS _____

CITY/STATE/ZIP _____

EMP. PHONE _____ SOCIAL SECURITY # _____

MOTHER'S NAME _____ EMPLOYER _____

EMPLOYER'S MAILING ADDRESS _____

CITY/STATE/ZIP _____

EMP. PHONE _____ SOCIAL SECURITY # _____

PRIMARY INSURANCE
COMPANY NAME _____

EMPLOYER, GROUP, OR INDIVIDUAL _____ IN WHICH PARENT'S NAME _____

GROUP # _____ CONTRACT # (POLICY ID #) _____

MAILING ADDRESS
FOR CLAIMS _____ CITY/STATE/ZIP _____

SECONDARY INSURANCE
COMPANY NAME _____

EMPLOYER, GROUP, OR INDIVIDUAL _____ IN WHICH PARENT'S NAME _____

GROUP # _____ CONTRACT # (POLICY ID #) _____

MAILING ADDRESS
FOR CLAIMS _____ CITY/STATE/ZIP _____