



Consent to Medical Care for a Minor

By signing this form, I (we) hereby authorize _____
 the (select one) Aunt Uncle Grandparent Sibling (adult) Family Friend other _____
 to accompany our child: _____, born ____/____/____ and act as
 Guardian/Caregiver for medical appointments with **Brummitte Dale Wilson, MD & Associates**, as well as to
 verify or update our child's current insurance information. ***I (we) also consent to any medical care and
 treatment that is recommended by the physicians and agreed upon by the Guardian/Caregiver, and as such
 accept all financial responsibility for care provided.***

Medical History

(Failure to complete any of the following does not impair the validity of this consent to medical care for a minor)

Allergies

Current Medications

Other Pertinent Health Issues

Pediatrician

Pediatrician's Telephone

In order to ensure that the Child receives prompt medical care and treatment when necessary, I (we) hereby
 release any licensed health care provider providing medical care to the Child in reliance of this form from
 liability relating to such provider's acceptance of my (our) substitute care giver's consent.

This Consent is dated ____/____/____ and is valid for: ____/____/____ *specific appointment date*
OR one month one year indefinite
 other _____

In the event of an emergency, I can be reached at _____.

Signed:

_____/____/____
 Parent's Signature Date Print Name

_____/____/____
 Second Parent's Signature (optional) Date Print Name