

CONSENT FOR MEDICAL TREATMENT FOR CHILDREN UNDER 18 YEARS OF AGE IN PARENTS OR GUARDIAN ABSENCE

Parent or Guardian (Please Print): _____
Name

Relationship: _____
Mother/Father/Legal Guardian

Child: _____
Name

Date: _____

I hereby voluntarily consent to the rendering of medical care, including, but not limited to, diagnostic procedures, surgical procedures, medical treatment and allergy injections by Dr. David C. Wenger-Keller, or by authorized members of his staff in my absence.

This consent expires one year from signing unless otherwise specified. I may also revoke this at any time in writing.

Signature: _____