

PARENTAL CONSENT TO TREAT



We, \_\_\_\_\_, as parents of the minor  
(Name of parents-Please Print)

children listed below, consent to any x-ray examination, anesthetics, medical or surgical diagnostic or treatment procedures deemed necessary for the treatment by our pediatrician, Joseph E. Cangas, M.D., or the emergency physician on duty at a hospital.

Name	Birthdate	Allergies

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage said physicians to exercise their best judgment as to requirements of such diagnosis or treatment.

This consent shall remain effective for one year unless sooner revoked in writing and delivered to said physicians.

Dated \_\_\_\_\_

\_\_\_\_\_  
Father

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Mother

\_\_\_\_\_  
Legal Guardian or Responsible Party

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Number