

# NORTH TEXAS FAMILY MEDICINE

## AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD

I, (we) \_\_\_\_\_ of \_\_\_\_\_  
\_\_\_\_\_ County, \_\_\_\_\_, do hereby state that I am (we are)  
\_\_\_\_\_ County, \_\_\_\_\_ (State)  
the natural parent (s) having legal custody of \_\_\_\_\_  
\_\_\_\_\_ (Child's name)  
a minor, age \_\_\_\_\_, born \_\_\_\_\_, who resides with me (us) at  
\_\_\_\_\_ (age) \_\_\_\_\_ (Date)  
\_\_\_\_\_  
\_\_\_\_\_ (Address)

I authorize \_\_\_\_\_, an adult, who resides  
\_\_\_\_\_ (Name)  
at \_\_\_\_\_ in the city of \_\_\_\_\_,  
\_\_\_\_\_ (address) \_\_\_\_\_ (City)  
county of \_\_\_\_\_, state of \_\_\_\_\_, to consent to  
\_\_\_\_\_ (County) \_\_\_\_\_ (State)

any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care,  
to be rendered to the minor under the general or special supervision and on the advice of any  
physician licensed to practice in the state of Texas, when the need for such treatment is  
immediate, and when efforts to contact me (us) are unsuccessful.

Date this \_\_\_\_\_ day of \_\_\_\_\_, (year) \_\_\_\_\_

\_\_\_\_\_  
(signature)

Child's allergies, if any \_\_\_\_\_

Medicines child is taking \_\_\_\_\_

Starting Date \_\_\_\_\_

Expiration Date \_\_\_\_\_