PARENT/GUARDIAN CONSENT TO MEDICAL, DENTAL, OR HOSPITAL CARE

Child's Name (Last)	(First)	(Middle)	Date of Birth
Address	City	State	ZIP Code
Parent/Guardian Name (Last)	(First)	(Middle)	
Telephone	Cell	E-Mail	

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Print Name of Parent/Guardian	
Signature of Parent/Guardian	Date