CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born

the ___ day of _____, 20___ do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of **an employee representative** of **Augustana University**, City of **Sioux Falls** State of **South Dakota, USA**
and I am not reasonably available by telephone to give consent.

This authorization is effective from the ___ day of _____, 20___ to

___ day of _____, 20___

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Witness Signature Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Child's Last Tetanus Vaccination: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____