



6200 E. Central • Wichita, KS 67208
(316) 858-5800 • Fax (316) 858-5850

CONSENT TO TREATMENT

We ask you to complete this form when you will be absent or unavailable for a period of time so as to ensure the delivery of care to your child is not unreasonably delayed.

I, _____, parent or legal guardian of _____, do consent to any hospital, medical or surgical care and treatment, and the administration of anesthesia, determined by a qualified physician to be necessary for the welfare of my child while said is under the care of _____,
(Name of Babysitter, Representative)
and I am not reasonably available by telephone to give consent.

(Signature of Parent or Legal Guardian)

(Witness)

Family Address: _____

Telephone : Mother _____ (Home) _____ (Work)
Father _____ (Home) _____ (Work)

Child's Date of Birth: _____

Last Tetanus: _____

Allergies to Drugs or Foods: _____

Special Medications, Blood Type or Other Pertinent Information:

Family Physician _____ Phone _____

Insurance _____ Policy # _____