Mid Coast Health System
CONSENT FOR TREATMENT OF MINOR

_________________________________, born_________________________, is a
Child's Name   Child's Date of Birth

minor child who resides at ____
Child's Legal Address

His/her parent(s)/Legal Guardian are/is______________________________________.
Parent's Name

I, ______________________________, the Parent / Legal Guardian of
Parent's Name

______________________________, authorize ______________________________,
Child's Name   Managing Conservator (person bringing child to office)

And Mid Coast Health System and/or such assistants as the Physician, Mid-Level Provider or Nurse Practitioner may designate, to treat the minor child on or about ______________, for the following condition(s)________________________________
Date of Service

____

____.

I further authorize the Physician, Mid-Level Provider or Nurse Practitioner to perform any procedure including diagnostic procedures such as x-rays that is deemed advisable in attempting to relive this condition or related unhealthy condition that any be encountered during any necessary operation or procedure.

I also consent to the administration of anesthesia to be applied by or under the direction of an anesthesiologist designated by the Physician, Mid-Level Provider or Nurse Practitioner and to use such anesthesia as deemed advisable.

The effect and nature of the treatments or operations to be performed, and the possibility of complications and unforeseen consequences have been explained to me. No warranty has been made as to the results to be obtained.

______________________________	______________________________
Witness	Signature of Parent/Guardian
______________________________	______________________________
Date	Relationship to Child