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 Thomas More College of Liberal Arts, City of _____ State of _____ and The Roots in Rome Program, City of_____, Country of _____ 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.

Family Address _____

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

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____