



SAVANNAH URGENT CARE
485 Jimmy DeLoach Parkway, Building B, Unit D
Savannah, GA 31407

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal
guardian of _____, born
_____, 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
_____ and I am not reasonably available
by telephone to give consent.

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian

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 _____

Telephone: Father _____ home _____ work _____

Mother _____ home _____ work _____

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____

Special Medications, Blood Type or Pertinent Information

Child's Physician _____ Phone _____

Insurance _____ Policy # _____

Preferred Hospital _____