Alternative Persons Consent to Medical Treatment of a Minor

(Only for use when parent/legal guardian cannot be contacted and has not given actual notice to the contrary)

I consent to the following surgical, medical and/or diagnostic treatment procedures for:

____: ________________________

Name of Minor Patient

____

____

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The treatment will begin on: ____________________________________.

Date

The parent/legal guardian of the minor (named below) cannot be contacted and has not given actual notice to the contrary to this consent.

_________________________________/______________________________

Mother's Name Father's Name

________________________________/_______________________________ (if applicable)

Managing Conservator's Name Guardian's Name

DATE: ____

SIGNED: ____/______________________

Relationship to Minor

WITNESS: _______________________________________/_______________________

Print Name