

**Orange County Children's Medical Group  
Parent/Guardian Consent for Medical Treatment**

*Child's Information*

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Parent/Guardian Name(s)

\_\_\_\_\_  
Parent/Guardian Phone #

*Caregiver Information*

\_\_\_\_\_  
Caregiver's Name and Relation

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Caregiver's Name and Relation

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Caregiver's Name and Relation

\_\_\_\_\_  
Phone Number

The above named person(s) shall be authorized to bring my child to medical appointments and make medical decisions for my child **in my absence**.

Please attempt to contact me at the following telephone number: \_\_\_\_\_ if you need any further authorizations.

This consent serves as permission for treatment by Orange County Children's Medical Group.

Note: I agree to pay for all services provided to my child in my absence.

Signatures:

\_\_\_\_\_  
Parent/Guardian

Date

\_\_\_\_\_  
Witness

Date