UCSF Benioff Children's Physicians

Consent to Treatment of a Minor

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an UBCP clinical facility. This authorization is effective from _____ until
(Today's Date)
consent is withdrawn.

Signature of Parent/Legal Guardian **Today's Date**

Other Adult Consent to Treatment (Optional)

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize _____ to act as my agent to consent to any
(Printed Name Agent/Other Adult)
x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from _____ until consent is
(Today's Date)
withdrawn.

Signature of Parent/Legal Guardian **Today's Date**