SANTA MONICA
FAMILY PHYSICIANS

Consent to treat Minor/Dependent

Patient Name: _____ Date of Birth_____
(Please print)

As parent / guardian of _____
(Name of Child or Dependent- Please print)

I hereby authorize treatment for medical service and emergencies, if I cannot be reached for verbal authorization. I understand that this will allow Santa Monica Family Physicians to provide medical and emergency care which might include administration of medications, minor trauma surgeries, application of temporary splints or braces, or other procedure deemed acutely necessary to ensure the health and safety of my child / dependent. I understand that all efforts will be made to contact me or the designated representative prior to treatment.

_____ _____
(Parent or Guardian- PRINT) (Designated Representative- PRINT)

_____ _____
(SIGNATURE: Parent or Guardian) (SIGNATURE: Designated Representative)

_____ _____
Address Address

_____ _____
City State ZIP City State ZIP

_____ _____
(Phone (Home) (Phone (Home)

_____ _____
(Phone: Work / Daytime) (Phone: Work / Daytime)

REV 7/29/2017