PATIENT:_____________________________ DOB___________

CONSENT FOR TREATMENT OF MINOR CHILDREN

Accompanied by an adult other than parent or legal guardian

I, ____

(Parent or legal guardian)

Authorize Coastal Healthcare to treat (child) ___________________________
for routine and emergency medical treatment when deemed necessary by
qualified medical personnel when accompanied by:

________________________________ Relationship to child:______________
________________________________ Relationship to child:______________
________________________________ Relationship to child:______________

This authorization is valid for:

____ Today's visit only Date:_______________

____ From (date) __________________ to (date) ____________________

____ Until revoked in writing by me

THIS CONSENT WILL BE VALID FOR ONE (1) YEAR FROM THE DATE SIGNED

Printed name of parent/legal guardian___________________________________

Signature of parent/legal guardian_____________________________________

Date:_____________________