Consent for Medical/Surgical/Emergency Care and Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: ____________________________for ______________________ Date of Birth: ________

☐ Mother ☐ Father ☐ Legal Guardian ☐ Daughter ☐ Son

We/I hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical, and medical treatment, by authorized members of Arlington Physicians, P.A. and their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to ____
(Name of Person/Agency)

who will be caring for our (my) child ____
(Name of Child)

For the period _________________________to _____________________to arrange for routine or emergency medical care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature _____________________________________ Date ____________________
(Mother, Father, or Legal Guardian)

Printed Name __________________________________

In case of emergency, I can be reached at:

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