The Children's Clinic, Inc.
4001 Dale Street Suite 213
Anchorage AK 99508-5496

CONSENT FOR THE TREATMENT OF A MINOR

This Authorizes _____ or _____
Must Be 19 years or Older

to give consent for medical treatment for my child/children:

Child Name	Date of Birth

In the event that neither parent or guardian is available at the time for such consent for treatment is needed, this consent will be in effect starting this day, _____ and ending, _____. The authorized adults should be prepared to verify his or her identity to correspond with the names stated in this authorization, should the need for medical care arise.

Signatures_____ and/or _____
Father/Guardian Date Mother/Guardian Date

_____
Witness (not a family member) Date

Parent/Guardian Home Address:_____Phone_____

Employer:_____Phone_____

Health Insurance Company:_____Phone_____

Authorized Home Address:_____Phone_____

Chronic illnesses or allergies of the above named children:

Child Name	Illness or Allergy