# Parental Consent for Medical Treatment

Date: _____

To Whom It May Concern,

I, **[Parent/Guardian Name]**, am the parent/legal guardian of **[Child's Full Name]**, born on **[Child's Date of Birth]**.

I hereby give my consent for my child to receive medical treatment as deemed necessary by the medical professionals at **[Name of Medical Facility or Practitioner]**.

This consent includes, but is not limited to, the administration of medication, diagnostic testing, and any necessary emergency medical procedures.

If I cannot be reached in case of an emergency, please contact the following individuals:

- **[Contact Name 1]** - [Phone Number]
- **[Contact Name 2]** - [Phone Number]

My signature below indicates that I have read and understand the terms of this consent form.

Signature: _____

Printed Name: _____

Relationship to Child: _____

Address: _____

Phone Number: _____

Email: _____