

# Child Medical Treatment Consent Form

Date: \_\_\_\_\_

To Whom It May Concern,

I, the undersigned, hereby give my consent for the medical treatment of my child:

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I understand that my child may require medical treatment, including but not limited to:

- Physical examinations
- Diagnostic tests
- Vaccinations
- Emergency medical care

I authorize the medical staff to carry out necessary procedures as deemed appropriate. I acknowledge that I have been informed of any potential risks associated with the treatment.

In case of an emergency, I can be reached at:

**Parent/Guardian Name:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_

Thank you for your attention to my child's medical needs.

Sincerely,

**Signature of Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_