



## Consent for Medical Care of a Minor

I hereby voluntarily consent to the rendering of medical care to my child or ward including but not limited to diagnostic procedures, surgical and medical treatment by members of the Carbon Health staff or their designees, as may in their professional judgment be necessary.

Child's Name

Date of Birth

Blood Type

Home Address

## Allergies

### Current Medications

Emergency Contact Name

Phone Number

I hereby authorize the individual(s) listed below to arrange for routine or emergency medical care and treatment necessary to preserve the health of my child or ward.

Authorized Individual

Relationship to Child

Phone Number

Authorized Individual

Relationship to Child

Phone Number

**P: 415.612.3256**

**F: 888.972.1912**

**E: [hello@carbonhealth.com](mailto:hello@carbonhealth.com)**

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered to my child or ward while in the care of the authorized individual(s).

This consent shall be valid for the period \_\_\_\_\_ to \_\_\_\_\_.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition. I have read this form and certify that I understand its contents.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date