Stonecreek Family Physicians, LLP
Consent for Treatment of Child

I/We ___________________________. Parent(s) of ________________

hereby authorize, ______________________________ to act in my/our

behalf in the event my child becomes ill and/or needs to have medical care

provided, any such medical care necessary to preserve life. This care may

include medical diagnosis and treatment or surgical treatment as needed

to preserve life. These services may be provided at a hospital or in a

physician office.

My/Our health insurance:_____________________________________

This child takes medications (and dosage) as listed:___________________

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Known Allergies:____

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Parent(s) Signature Date

____

Witness Signature Date