MINOR'S MEDICAL TREATMENT CONSENT FORM

Authorization and Consent to Treat in the Absence of Parent or Guardian

MONTEREY PENINSULA
pediatric
MEDICAL GROUP

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I, _____ authorize the following person(s):
(Please print first and last name)

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

To consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care deemed advisable by a physican in Monterey Peninsula Pediatric Medical Group's practice.

This authorization is for my child/children:

First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth

Parent/Guardian Signature **Date**

This authorization is made under Family Code #6910.