Enroute to Better Health

Christina Tillia LMT, HHP, CTN #09018, Lic #5048
911 N Hallett Cir
Farmington, NM 87401

Child Name: ______________________________ Birthdate: _________

Social Security #:_________________________________

Address: ____

City:_________________________________ State: ______ Zip:_________________

Home phone: ______________________ Work Phone: _______________________

Parental Consent

(I)(We), the undersigned, parent(s) of _________________________, a minor, do hereby consent to said minor participating in __________________________ (explain activity) conducted by ________________________.

Authorization of Consent to Treatment of Minor:

(I)(We). The undersigned parent(s) of _________________________, a minor, do hereby authorize ________________________, hereinafter "Agent," for and on behalf of the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital, during all times that the minor is in the presence of said Agent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgement may deem advisable and release Agent from all damages of same.

This authorization shall remain effective through the ____ day of ____________ 20 __, unless sooner terminated in writing.

Parent signature: ____

Date:_______________________

Home Phone: _______________________ Work Phone: _______________________

Other phone: _________________________

Legal Guardian: ___________________________ Phone: ______________________

Other emergency contact: ______________________ Phone ___________________

Known Medical Conditions:

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