MEDICAL CONSENT FOR TREATMENT OF A MINOR

I,_____, certify that I am the parent or legal guardian of the minor child listed below, and as such, I hereby give my consent to allow Be Well Women's Health to medically treat the minor child as may be deemed necessary for the well-being of my child, when not accompanied by a parent/legal guardian or should either parent/legal guardian be unreachable by telephone. I also submit that I will be responsible for all reasonable charges for care and treatments rendered.

_____ _____

(Signature of Parent/Legal Guardian) (Date)

_____ _____

(Name of Parent/Legal Guardian) (Relationship to Child)

_____ _____

(Home/Work Number) (Cell Number)

MINOR CHILD

Child's Name: _____

Address: _____

Telephone Number: _____

Date of Birth: _____

Parent/Legal Guardian: _____

Address: _____

Home/Work Telephone: _____

Cell Telephone: _____

Allergies: _____

Medical Conditions: _____

Current Medications: _____

PRIMARY CHILD CARE PROVIDER

(Primary Child Care Provider Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

AUTHORIZED EMERGENCY CONTACTS

(Emergency Contact Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

HEALTH INSURANCE & DOCTOR INFORMATION

Insurance Company: _____

Policy Number: _____

Group Number: _____

Physician's Name: _____

Address: _____

Telephone Number: