UCSF Benioff Children's Hospitals

eastbaypediatrics

Consent to Treatment of a Minor

I, _____, parent or legal guardian of
Printed name of parent/guardian

_____, born on _____
Patient full name Patient Date of Birth

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures, and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of East Bay Pediatrics, a UCSF Health Medical Foundation clinical facility.

This authorization is effective from _____ until consent is withdrawn.
Today's date

_____ _____
Signature of Parent/Legal Guardian Today's date

Other Adult Consent to Treatment (optional)

I, _____, parent or legal guardian of
Printed name of parent/guardian

_____, born on _____
Patient full name Patient Date of Birth

Do hereby authorize any of the below listed adults to act as my agent to consent to any Xray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless where treatment is provided.

_____ _____
Printed name of Agent/Other Adult relationship to patient

_____ _____
Printed name of Agent/Other Adult relationship to patient

This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from _____ until consent is withdrawn.
Today's Date

_____ _____
Signature of parent/legal guardian Today's date