Alternative Persons Consent to Medical Treatment of a Minor

(Only for use when parent/legal guardian cannot be contacted and has not given actual notice to the contrary)

I consent to the following surgical, medical and/or diagnostic treatment procedures for:

_____: _____
Name of Minor Patient

_____

_____

_____

The treatment will begin on: _____.
Date

The parent/legal guardian of the minor (named below) cannot be contacted and has not given actual notice to the contrary to this consent.

_____/_____
Mother's Name Father's Name

_____/_____ (if applicable)
Managing Conservator's Name Guardian's Name

DATE: _____

SIGNED: _____/_____
Relationship to Minor

WITNESS: _____/_____
Print Name