Project Discovery
CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____ _____, whose birthday is_____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of the Employees of Project Discovery, City of Reno, State of Nevada, if I am not reasonably available by telephone to give consent. This authorization is effective from _____ to _____.
(beginning date) (ending date)

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Signature Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____
Father's Telephone: _____ Mother's Telephone: _____
Last Tetanus: _____
Allergies to drugs or foods: _____
Special Medications, Blood Type or Pertinent Information: _____
_____
Child's Physician: _____ Phone: _____
Insurance: _____ Policy # _____
Preferred Hospital: _____

May Project Discovery Staff administer age appropriate doses of Tylenol, Ibuprofen, Benadryl, and/or other over the counter medication in the event that child has a headache, stomach ache, minor injury, minor allergic reaction, etc?

____Yes ____No Initials _____