MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, Building E23
Cambridge, MA 02139

MIT Health

Consent for Treatment of a Minor

MRN: ______________________________

I / we ______________________________
Name of Parent/Guardian

residing at ______________________________
Home Address

phone number ______________________________
Home Phone

the parent(s) or legal guardian(s) of ______________________________
Child's Name

born on ____________ , hereby grant permission to ______________________________
Child's DOB Name

residing at ______________________________ , phone number ____________
Home Address Home Phone

to consent and to authorize medical and hospital care and treatment for the above child during my / our absence for the period commencing on ____________ and ending on ____________
Date Date

I / we hereby indemnify and hold harmless the provider, and other persons who act in reliance of this authorization.

Child's primary care provider: ______________________________ ____________
Name Phone Number

Child's Medical History

Chronic or preexisting conditions: ______________________________

Allergies to medication: ______________________________

Current medications: ______________________________

Executed on ____________ by: ______________________________
Date

Signature of parent or guardian ______________________________

Signature of parent or guardian ______________________________