



Consent for Medical Treatment for Minor/Child's

In presenting my son/daughter for diagnosis and treatment:

Name: _____ for _____
()Mother ()Father ()Legal Guardian () Son () Daughter

of _____ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of **Unite Here Health-Health Center** staff, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

**We/I hereby give our (my) consent to: Unite Here Health-Health Center
1801 Atlantic Ave, 3rd Floor
Atlantic City, NJ 08401**

Who will caring for my child: _____ DOB: _____

In case of emergency:
Print Name: _____ Telephone: _____

Signature: _____ Date: _____