CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____ Parent or Legal Guardian
Name of parent or guardian

of _____ Child's date of birth: _____
Name of child

Give my consent to any medical care deemed to be necessary for my child.

This authorization is effective from _____ to _____

_____ _____
Signature of Parent or Legal Guardian Date

Please have the child bring this consent form to the office and present it at check in. We are unable to see a minor child without a signed consent.