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CONSENT TO TREATMENT OF MINOR CHILD

Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

I am the legal guardian of the above named child. I understand that I should accompany my child to all office visits and agree to make every effort to be present whenever my child is in need of medical services. On these occasions when it is impossible for me to accompany my child, I designate the following people as authorized to act on my behalf with regard to making medical decisions for my child during the visit:

Adult's Name	Relationship to Child:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may revoke this consent at any time but must do so in writing.

Parent/Legal Guardian Name: _____
Relationship to Child: _____
Address: _____
_____ Phone #: _____

Signature of Parent/Guardian: _____
Date of Signature: _____

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