CONSENT TO TREAT A MINOR

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT

Patient Name: _____DOB: _____

Please try to contact me (us) regarding the health care of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

Signature: _____

Date: _____

Print name and relationship: _____

***NOTE**: If any special parental or custodial relationship (such as custody with one parent only, legal custody/ guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and phone number at which you can be contacted.*

_____
_____
_____
_____
_____

Signature: _____

Printed name: _____

Phone: _____