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WEBSITE:
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MEDICAL PERMISSION TO TREAT A MINOR

_____
Today's Date

_____ _____ _____ _____/_____/_____
Child's Last Name First Name Date of Birth

_____ _____ _____
Last Name of Parent or Guardian First Name Relationship

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Cell Phone Number

I am the parent or guardian for the above identified patient. I have provided documented evidence to identify myself. (Requires a copy of a driver's license with a photo and one other form of identification on file.) I hereby assert and claim that I am authorized to give permission to the person identified below as my agent to represent me as my child's guardian exclusively for the purpose to authorize treatment and necessary services to the above named child. I further understand that any instructions that are given to this agent for the care and treatment of this child is my responsibility.

In accordance with the authority vested in me I hereby authorize the person identified below to act as my agent to authorize medical services.

_____
Print Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Witness

_____ _____ _____
Last Name of Agent First Name Relationship