MEDICAL CONSENT FOR A MINOR CHILD

I_____, the parent or legal guardian of the following child(ren)

_____ (child's name and date of birth)

_____ (child's name and date of birth)

_____ (child's name and date of birth)

_____ (child's name and date of birth)

Do hereby consent and allow _____ (name of person parent is authorizing consent) to handle any type of medical treatment for sick office visits or well office visits and all vaccinations.

This authorization is effective from _____ (date) and will not expire unless the parent or guardian asks for the consent to be removed.

_____ (signature of parent or guardian)

_____(date) _____(printed name of parent)

Parent or Guardians information

Fathers name _____ Father Phone#_____

Father's signature_____

Mothers name_____ Mothers Phone#_____

Mother's signature_____

Any special instructions:

_____

_____

_____

_____