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PERMISSION FOR TREATMENT

Patient Name: _____ Date of Birth: _____Date: _____

I give permission for the following people to seek and obtain medical care and treatment from Family Health Center for my child.

Name	Relationship to Child	Phone #
Name	Relationship to Child	Phone #
Name	Relationship to Child	Phone #

(I)(We), the undersigned, (Parents) (Legal Guardians) do hereby consent to and authorize Family Health Center to perform any necessary medical or surgical examination or treatment which is deemed advisable by a licensed medical practitioner at Family Health Center. I also understand that I am allowing the above-named caregivers the ability to make medical decisions for my child on my behalf, in my absence. I further understand that I remain the financially responsible party for my child's medical care.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Printed Name Date