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**The  
Family Physicians  
Group, P.C.**

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- ▶ I, \_\_\_\_\_, hereby consent to any and all reasonably necessary medical examination(s) and health care procedures performed by the physicians and/or any of the nurses or medical staff employed by The Family Physicians Group, P.C., including but not limited to the administration of medication, any lab procedures, the taking of x-rays, the drawing of blood, or any other treatments that are deemed reasonably necessary by the physicians at the time of my examination.

\_\_\_\_\_  
Patient or Legal Representative  
(Parent or Guardian, if patient is a minor)

\_\_\_\_\_  
Date