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Permission to Treat Form

NOTE: This form is NOT valid for Preventative/Well Child exams/vaccines.
Only Acute care.

Date: _____

To Whom It May Concern:

I, _____, guardian of _____ give my
(Biological Parent/Guardian's Name) (Child's Name)

Permission for: _____
(Caretaker's Name) (Relationship to Child)

(Caretaker's Name) (Relationship to Child)

(Caretaker's Name) (Relationship to Child)

to seek medical treatment & make decisions for my child as necessary on my behalf. The duration of this authorization is indefinite and continues until revoked in writing.

Parents Signature _____ Date _____

Witness Signature _____ Date _____

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