Unity health network
Family Medicine
Internal Medicine
& Pediatrics

CONSENT FOR TREATMENT OF MINORS

(THIS FORM MUST BE COMPLETED YEARLY)

I, _____ give permission for medical treatment
(PARENT OR LEGAL GUARDIAN)

for _____ to the physicians, Physician's assistant, or Nurse Practitioner
(NAME OF MINOR CHILD)

at this medical practice at: _____
(ADDRESS OF OFFICE PRACTICE) (CITY, STATE)

Furthermore, I give permission for _____
(NAME OF PERSON(S) WHO WILL BRING MINOR FOR TREATMENT IN ABSENCE OF PARENT OR GUARDIAN)

to bring the below - mentioned child/children for treatment.

NAMES AND BIRTH DATE OF CHILD/CHILDREN

- _____
- _____
- _____
- _____
- _____

Signature of parent or guardian: _____Today's Date: _____