



Parental Consent

I give permission for the persons listed below to bring my child, _____
(patient's name)
to Children's Medicine P.C. for medical treatment.

(name)

(relationship to patient)

(name)

(relationship to patient)

(name)

(relationship to patient)

(name)

(relationship to patient)

(signature of parent or guardian)

(date)

*revised 12/21/2011