



Parental Consent

I give permission for the names 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)

(signature of parent or guardian)

(date)

* FOR MINORS, AGE 16 AND UP

I give permission for my child, _____ to be seen and receive treatment without a parent or
(patient's name)
legal guardian present.

(signature of parent or guardian)

(date)