



PARENT/GUARDIAN CONSENT

I _____, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical evaluation of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the legal guardian and/or parent(s) to bring patient for any medical evaluation deemed necessary for the well-being of my child(ren) and to sign for necessary treatment.

I am legally responsible and have the authority to consent for all medical care and treatment of said child(ren):

_____	_____
Patient Name	Patient Name
_____	_____
Patient Name	Patient Name
_____	_____
Patient Name	Patient Name

I authorize, this/these person(s) bring child(ren) for medical evaluation and consent to treatment and care;

_____	_____
Name	Relation to patient(s)
_____	_____
Name	Relation to patient(s)
_____	_____
Name	Relation to patient(s)
_____	_____
Name	Relation to patient(s)

Parent or Guardian Signature **Date**

OFFICE USE:
 STAFF _____