

FamilyCare HealthCenter

PERMISSION TO TREAT A MINOR

CHILD

Child's Name: _____ Birthdate: _____

Allergies: _____

Gender: *Female or Male*

PARENT / GUARDIAN

Father: _____
(Cell) _____

Phone (H) _____ (W) _____
Email: _____

Mother: _____
(Cell) _____

Phone (H) _____ (W) _____
Email: _____

Guardian: _____
(Cell) _____

Phone (H) _____ (W) _____
Email: _____

I give permission to the following people to accompany my child to his/her medical visit.

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Signature of Parent or Guardian

Date

Disclosure: I understand this permission may be taken back or changed in writing although the change will not affect previous permissions.