CONSENT TO EVALUATE AND TREAT MINOR CHILDREN WITHOUT PARENT PRESENT

Please print all information

I, _____, parent or legal guardian (please circle one)

of _____, hereby authorize _____

to act in my place and assume responsibility/permit decisions for evaluation and treatment to be made on his/her behalf.

This consent does not expire without receipt of written documentation terminating this consent.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Notary Signature Notary Name (please print)

Notary Seal or Stamp

This consent form should be taken with the child to the physician's office when the child is taken for treatment.