North Valley Family Medicine

CONSENT TO TREAT A MINOR

I hereby authorize the physicians of North Valley Family Medicine, and whomever he or she may designate, to perform examinations and administer treatments as deemed necessary to:

Please Check the following:

Patient's Name DOB

I, _____, authorize the following individual(s) to act on my behalf to any treatment deemed necessary for my child:

_____ (Name) _____ (Relationship)

_____ (Name) _____ (Relationship)

_____ (Name) _____ (Relationship)

_____ (Name) _____ (Relationship)

____ I give consent for my child to be treated without an adult present

Parent Signature Date