



**Permission to Treat Minors**

I, \_\_\_\_\_, hereby give permission to the individuals listed below to bring my child(ren) to The Family Doctor and to make any and all medical decisions at the time of the visit. This permission will remain in effect until such time that I specifically revoke it.

Children's names:

_____	_____
_____	_____
_____	_____

People who may bring the child(ren):

_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

For any of my children who are 16 years of age or older or for any who later turn 16 years of age, I give permission for them to present to The Family Doctor for care without the presence of an adult guardian. This permission will remain in effect until such time that I specifically revoke it.

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date