



NAME OF OFFICE PRACTICE: _____

PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

I, the Legal Guardian of the minor child(ren) _____ give my
(Print minor child(rens') name)

consent for _____ to be accompanied by the individuals listed
(Print minor child(rens') name)

below to office visits and treatment that requires only general consent. I have already signed the general consent form.

Name Relationship

Name Relationship

Name Relationship

Please complete this section ONLY if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent.

My minor child(ren) _____ has my permission to transport
(Print name of minor child(ren))

himself/herself to receive general treatment that does not require general consent which I

_____ as guardian, have already given.
(Print name of legal guardian)

You can contact me by phone:

Home: _____ Cell: _____ Work: _____

I understand that this consent is in place until revoked by me and/or the expiration of one year.

Legal Guardian Signature Relationship of legal guardian to child(ren) Date

ACCOMPANIMENT

NO ACCOMPANIMENT

SIGNATURE