CONSENT FOR MINOR TO RECEIVE MEDICAL CARE

I, _____, parent/legal guardian of
(print first and last name)

_____, born on _____,
(name of minor child) *(child's date of birth)*

do hereby give permission for _____, _____
(name of adult person authorized) *(relationship to child)*

to accompany my child to be evaluated and treated at New Medical Health Care.

This authorization is effective from _____ to _____ *(maximum 1 year)*
(MM/DD/YY) ***(MM/DD/YY)***

_____ _____
Signature of Parent or Legal Guardian **Date**

Notary Signature

State of _____

County of_____

This instrument was acknowledged before me on _____ by _____.

(Notary Stamp)

_____
Signature of Notarial Officer

My appointment expires:_____

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