2131 N Ridge Road, Wichita, KS 67212
Phone: (316) 773-1212
Fax: (316) 440-6601

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/YYYY) *(MM/DD/YYYY)*

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

_____ _____
Witness Signature Witness Name (please print)

Kansas Notary Acknowledgement

State of Kansas
County of _____

This instrument was acknowledged before me on _____ (Date) **by** _____
(Name(s) of Person(s)).

Signature of Notarial Officer: _____

Title and Rank: _____ **My Appointment Expires:** _____