AUTHORIZATION FOR TREATMENT TO MINOR

_____

MINOR'S FULL NAME

DATE OF BIRTH

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Parker Family Care to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventive and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

SIGNATURE-PARENT OR LEGAL GUARDIAN DATE

SIGNATURE-PARENT OR LEGAL GUARDIAN DATE

WITNESS DATE