PERMISSION FOR TREATMENT OF CHILDREN

NAME OF CHILD: _____

DATE OF BIRTH: _____

NAME OF PARENT/LEGAL GUARDIAN: _____

If I can't bring my child to a medical or dental appointment, I give permission for the person(s) listed below to go with my child to visits at ***Family First Health***. He/she can also approve treatment for my child during the visit, including shots.

Name	Relationship to Child
Name	Relationship to Child
Name	Relationship to Child

This permission is in effect for 1 year from the date signed, unless I cancel it in writing to ***Family First Health***.

Parent/Guardian Signature	Date
Witness Signature	Date

PLEASE NOTE: Sometimes, the doctor may decide that a parent must be present for certain visits.