FAMILYFIRST HEALTH

PERMISSION FOR TREATMENT OF CHILDREN

Name of Child:	Birthdate:
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.