



# CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. \_\_\_\_\_

\_\_\_\_\_ and/or his staff to examine and/or  
treat my daughter/son.

Full Name of Child

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Witness \_\_\_\_\_

Dated \_\_\_\_\_

