PERMISSION TO OBTAIN MEDICAL TREATMENT WHEN A PARENT OR GUARDIAN IS NOT PRESENT

I/We _____
(parent(s)/guardian(s) first and last names)

give my/our permission for _____
(first and last name of adult authorized to obtain care)

to seek medical attention at **Providers for Healthy Living** and receive

treatment for my/our child(ren):

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I/We can be reached at _____ during office hours, if needed.

_____ _____
Parent(s)/Guardian(s) Signature Date

_____ _____
Parent(s)/Guardian(s) Signature Date