



# CONSENT FORM

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## Minor Care Authorization

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby give permission for Dr. \_\_\_\_\_ to examine and treat my child, who is a minor.

Signature of Parent/Legal Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_