MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

I hereby authorize the staff and physician(s)/provider(s) of Vascular Health to administer medical treatment/care as he/she deems necessary for the following child:

Child's Name: _____ Date of Birth: _____

This grant of authority shall begin on today's date _____ and shall remain effective until terminated by the undersigned.

_____
Printed Name of Parent or Guardian on Minor Patient

_____
Signature of Parent or Guardian on Minor Patient

Relationship to Minor: _____

Copy Goes to Parent or Legal Guardian