

# Calvary Medical Clinic



*"Where Your Healing Begins"*

## CONSENT FORM FOR TREATMENT OF CHILD

I, \_\_\_\_\_,  
(Printed name of parent/legal guardian)

Cannot accompany my child, \_\_\_\_\_,  
(Printed name of child/DOB)

To: Calvary Medical Clinic., therefore, I give permission to:

\_\_\_\_\_ as follows:  
(Printed name of individual bringing child in) (relationship)

I give permission for this person to seek medical treatment (including any type of procedure, test, immunization, injection and blood draw or lab test) and provider consent for such treatment without having to contact me.

### EXPIRATION OF PERMISSION (CHECK ONE)

\_\_\_\_\_ This form will remain in effect until revoked

\_\_\_\_\_ This form is VALID ONLY during the following timeframe:

Effective date: \_\_\_\_\_ / Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Print name

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date \_\_\_\_\_

Cleveland Clinics  
108 S. William Barnett Ave  
Cleveland TX 77327  
281-592-9775  
Fax: 281-432-0548

Livingston Clinic  
309 Hwy. 59 S. Loop  
Livingston, TX 77351  
936-327-1055  
Fax: 936-329-8800

Humble Clinic  
8484 Will Clayton Pkwy  
Humble, TX 77338  
832-995-5200  
Fax: 281-995-5201