PERMISSION TO AUTHORIZATION TREATMENT OF MINOR

I_____give_____
(Parent's name) (Person accompanying child)

permission to authorize any medical treatment including administration of vaccines, performance of lab tests and surgical procedures for my child

_____.
(Child's Name)

I agree to assume financial responsibility for these services and provide necessary insurance information for billing purposes if applicable. This document should be valid for one year from date below unless stated otherwise here:

Signature_____ Date_____