San Dimas Family Practice
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SAN DIMAS FAMILY PRACTICE

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I hereby authorize San Dimas Family Practice. to provide medical examination and treatment to:

Name of Minor:____

(Please Print Clearly)

Date of Birth of Minor:__________________________________

I further authorize San Dimas Family Practice. to prescribe and administer, order x-ray and/or laboratory examinations and vaccinations, or other ancillary services deemed advisable.

____ ___________________________

Name of Parent or Legal Guardian Relationship

(Please Print Clearly)

____ ___________________________

Signature Date: