

Permission to Treat Minor

PATIENT INFORMATION (PLEASE PRINT):

Name: _____ Date of Birth: _____

Social Security Number: _____ Age: _____

Address:

Primary Phone: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name (Please Print): _____

Daytime Number: _____ Evening Number: _____

Emergency Contact (If you are unavailable): _____

Emergency Contact Number: _____

I give the Doctors at Eastbluff Medical Walk-In Wellness Center permission to treat my son / daughter / dependant without me being present.

BY MY SIGNATURE I AUTHORIZE THE TREATMENT OF MY MINOR CHILD WITHOUT MY PRESENCE.

Parent/Guardian Signature: _____ Date: _____