



NAME OF OFFICE PRACTICE: \_\_\_\_\_

### PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

I, the Legal Guardian of the minor child(ren) \_\_\_\_\_ give my  
(Print minor child(rens') name)

consent for \_\_\_\_\_ to be accompanied by the individuals listed  
(Print minor child(rens') name)

below to office visits and treatment that requires only general consent. I have already signed the general consent form.

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

**Please complete this section ONLY if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent.**

My minor child(ren) \_\_\_\_\_ has my permission to transport  
(Print name of minor child(ren))

himself/herself to receive general treatment that does not require general consent which I

\_\_\_\_\_ as guardian, have already given.  
(Print name of legal guardian)

You can contact me by phone:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

I understand that this consent is in place until revoked by me and/or the expiration of one year.

\_\_\_\_\_  
Legal Guardian Signature Relationship of legal guardian to child(ren) Date

ACCOMPANIMENT

NO ACCOMPANIMENT

SIGNATURE