EAGLE PHYSICIANS @ LAKE JEANETTE

CONSENT FOR TREATMENT OF A MINOR

Please take note:
Minors will not be treated without a parent or designated authorized person present.

I (we) the undersigned parent/guardian of _____a minor, do hereby consent to and authorize any medical provider of Eagle Physicians @ Lake Jeanette to provide necessary care/treatment to said minor as a patient.

I authorize the following individuals to bring my child in for care/treatment:

_____Relationship: _____

_____Relationship: _____

I am fully aware that the above named are the only individual(s) who will be allowed to be present with the above named minor for treatment. If anyone other than the above named person brings my child in to the Family Eagle Physicians @ Lake Jeanette for treatment, without a signed authorized note, I understand that the minor will not be seen and the appointment will have to be rescheduled.

This authorization shall be valid for the period of time commencing _____ and ending _____.

I do hereby indemnify and hold harmless the providers, Eagle Physicians @ Lake Jeanette, who act in reliance upon this authorization. I further agree to reimburse the health care provider for the cost of rendering these services.

Executed this: _____day of_____,20 _____

Parent/guardian:_____Witness: _____

INFORMATION

Parent/guardian can be located at: Address_____

Telephone numbers: Home _____Work_____

Cell _____

NO IMMUNIZATIONS WILL BE ADMINISTERED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT.