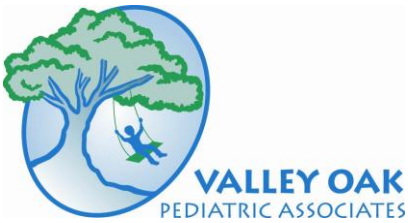

AUTHORIZATION TO CONSENT TO TREAMENT OF MINOR

I/We, _____ the undersigned Parent(s)/Legal Guardian of:
(Print Parent/Legal Guardian Name)

Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____

Minor(s), do hereby authorize (**i.e. name of relative, babysitter, friend, etc**.)

_____

to consent, in my absence, to any examination or treatment, including routine physical exams and immunizations, which is deemed advisable. It is understood that the authorization is given in advance but is given to provide authority and power on the part of our aforesaid agent to give specific consent. **This will expire one year from date signed.**

Emergency Contact (other than parents) _____

Relationship (to patient) _____Phone #_____

Date: _____

Print Name: _____ Signature: _____

Witness: _____