Island Family Medicine, PLLC
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CONSENT TO TREAT MINOR CHILDREN

(PLEASE PRINT ALL INFORMATION)

I, _____, parent or legal guardian of _____, born _____, do hereby consent to medical care and the administration of medication determined by a provider to be necessary for the welfare of my child while said child is under the care of (provider name) _____.

This authorization is effective for date of service: _____.

_____ _____

Signature of Parent/Legal Guardian Date

PLEASE READ

- **A new consent will need to be provided each time a minor child is seen without parent/legal guardian supervision.**
- **Form must be received in office at the time of the appointment, otherwise your child's appointment will be rescheduled to a later date and time.**