CONSENT TO TREATMENT OF MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. _________________________ including whomever he/she may designate as assistants to administer treatment as deemed necessary to:

____
Full name of Child

____
Child's Address

____
(City) (State) (Zip)

______/______/__________
Child's Date of Birth

____ ______/______/__________
Signature of parent or legal guardian Date

____ ____________________________
Printed Name of parent or legal guardian Relationship to Patient/Child

____
Witnessed by:

202 E Galena Boulevard (Route 30), Big Rock, IL 60511