David Barney Family Medicine
6690 Crossings Dr. SE suite C, Grand Rapids, MI 49508
p: (616) 600-1885
f: (616) 600-2782

Consent for Treatment of Minor

_____

Name of Patient Date of Birth

I, _____, am the parent or legal guardian of _____. I authorize that the providers at David Barney Family Medicine can provide necessary medical services and treatment to the abovenamed child, whether or not I am present when treatment is rendered.

The following individuals have permission to bring the above child for medical care if I am not available:

1. _____
2. _____
3. _____
4. _____
5. _____

_____
Signature of patient or personal representative

_____
If signed by personal representative, relationship to patient

_____
Date