NATOMAS FAMILY PRACTICE
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CONSENT TO TREAT A MINOR

I,_____, the parent(s) of
(Parent/Guardian Name)

_____
(Child's Name and Date of Birth)

may not always be able to accompany my child to his/her appointment(s). I am giving permission to NATOMAS FAMILY PRACTICE to give treatment without me being present for the office visits.

If there are any questions pertaining to the visit, I can be contacted at

_____. I understand that this consent expires one year from
(Phone Number)

date signed.

_____ _____
(Parent/Guardian Signature) (Date)

_____
(Print Name)