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CONSENT FOR TREATMENT OF MINOR CHILD

I authorize Family Medicine of Port Angeles to evaluate and/or treat any medical problems as necessary with or without my presence, until further notice. I understand I am still fully responsible for any medical expenses incurred.

Name of Child: _____ Chart #: _____

Limitations of Consent, if any _____

Presence of any medical conditions, allergies or regular medications: _____

Signed: _____ Date: _____

Relationship to Minor: _____

Address of Parent/Guardian: _____

Parent/Guardian Home Telephone: _____

Parent/Guardian Work Telephone: _____