7875 East Florentine Road, Suite A

Prescott Valley, AZ 86314

Phone: (928) 443-5599

Fax: (928) 443-5376

**Permission to Treat**

   ***\*Please only list one person per form\****

|  |
| --- |
| I, the undersigned parent, hereby give permission for the following adult (*name and relationship to child*) **\***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_who is over 18 years of age to bring my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*child’s name*) whose date of birth is \_\_\_\_\_\_\_\_\_\_\_\_.  By my signature, I authorize the **ADULT** named above to sign for any medical treatment, office procedures, injections of vaccines or medications, and physical assessments of health or illness effective from (*today’s date*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   |
| ***This Permission to Treat expires one year from date signed*** |
|  This Permission to Treat can only be revoked with my signature.   I, the parent/guardian, understand that I must grant this permission annually.  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Mother ( ) Father ( ) Legal Guardian  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Signature |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |