7875 East Florentine Road, Suite A

Prescott Valley, AZ 86314

Phone: (928) 443-5599

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**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 |