Grace Health

Consent for Treatment

Please plan to come to each visit with your child. We can give better care and answer your questions when we talk with you directly about your child.

If you are not able to come to the appointment, make sure the adult listed on this form knows about your child and will tell you what happened at the visit.

Please complete the following information for our records.

I, ____, give my permission for
Name of parent or legal guardian

________________________________, or _________________________________
Name of friend/relative — Name of friend/relative

or _______________________________, or _______________________________
Name of friend/relative — Name of friend/relative

to seek medical care for my child listed below. This includes but is not limited to obtaining prescriptions and consenting for immunizations, medicines and procedures.

____ ____________________
Name of child — Date of birth

_________ I also authorize Grace Health to reveal and discuss all medical information
(initials)

about my child to the above named persons.

This consent is effective as of today until rescinded or changed by me.

____ ____________________
Signature of parent or legal guardian — Date

____ ____________________
Witness — Date