

CONTINUING CONSENT FOR MEDICAL TREATMENT OF A MINOR

Date: _____ Expiration Date: _____

Patient Name: _____
Last First Middle

DOB: _____ / _____ / _____ Age: _____
Month Day Year

We/I, the undersigned parent(s)/legal guardian(s) of _____, a minor child, in our/my absence, do hereby consent to the physical examination and care of said minor as deemed medically necessary by Parkway Medical, PLC, primary care provider.

This consent shall remain in effect for one (1) year from the above date unless revoked sooner in writing and delivered to said provider and/or said persons entrusted with the custody of the minor.

We/I also understand and assume responsibility of making any applicable monetary payments as required by my insurance company at the time services are rendered.

Signature Relationship to Minor Date

Printed Name

Signature Relationship to Minor Date

Printed Name

1) _____
Signature of Witness Printed Name Date

2) _____
Signature of Witness Printed Name Date

(_____) We/I have received a copy of this form for our/my records.
Initials