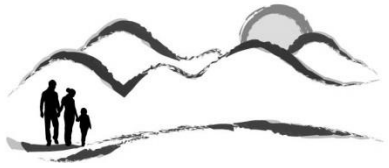
MIDWAY MEDICAL CENTER
Family Medicine



CONSENT FOR TREATMENT OF A MINOR

I hereby authorize **Midway Medical Center** and its staff to evaluate, treat and perform diagnostic testing for my

Child_____ Date of Birth_____

_____

Custodial Parent/Legal Guardian Date

PERMISSION TO PROVIDE SERVICES

I give permission to **Midway Medical Center** to provide health care services to my child _____ Date of Birth_____. Allergic reactions may be treated in my absence. Appointments with the physician *must* be attended by parent/guardian or a designated adult listed below.

1. My child may be seen without an adult escort for office visits (minor **16 years or older**) _____yes _____no (please initial)

2. My child may be brought to the office for treatment by the following person(s):

Name of adult Relationship to child

_____

_____

_____

_____

_____

Custodial Parent/Legal Guardian Date

Medical Services

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