



## Consent to Treat a Minor

Date \_\_\_\_\_

As guardians of \_\_\_\_\_, we hereby give Dr. Adams and all staff permission to examine our child. We agree to be financially responsible for all services rendered.

Guardian 1: _____	Relationship to Child _____
Date of Birth: _____	Guardian's Social Security: _____
Employed by: _____	Occupation: _____
Bus. Address: _____	Home Address: _____
Bus. Phone: _____	Cell Phone: _____
Drivers license: _____	Email Address _____

Guardian's Signature \_\_\_\_\_

Guardian 2: _____	Relationship to Child _____
Date of Birth: _____	Guardian's Social Security: _____
Employed by: _____	Occupation: _____
Bus. Address: _____	Home Address: _____
Bus. Phone: _____	Cell Phone: _____
Drivers license: _____	Email Address _____

Guardian's Signature \_\_\_\_\_

Name of Guardian with whom child lives \_\_\_\_\_

Name of Guardian with financial responsibility \_\_\_\_\_

Name, address, and phone number of friend or relative not at same residence \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

