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CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, (We) ___________________________ and _____________________________
(Name of Parent) (Name of 2nd parent if applicable)

Of (City)____________________________ (County)____________
(State)______________ , do herby state that I am (we are) the parent(s) or legal guardian(s) Of___________________________________ , a minor, age _______ , born _____ /____ /______. Who resides with me (us) at (current address)

Address: ____________________________City: ________________________State: ___Zip:_________

I, (We) authorize ____________________________ as a parent or guardian to consent to
(Name of Child)

Any necessary physical examination, pelvic exam, anesthetic, medical or special supervision and treatment. Upon the advice of the above provider or surgeon licensed to practice medicine in the State of Indiana.

Dated this __________day of ____________ (month) in the year _______________.

_______________________________ _________________________________
(Signature of Parent) (Signature of Witness)