

CONSENT TO TREAT A MINOR

NAME: \_\_\_\_\_

ADDR: \_\_\_\_\_

CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: \_\_\_\_\_ SS# \_\_\_\_\_

I HEREBY AUTHORIZE:

Dr. Alyssa Guglielmo or any doctors associated with the above named practice,

to administer the required care as deemed necessary to

my (indicate relationship of child) \_\_\_\_\_

(Name of Child) \_\_\_\_\_

SIGNED: \_\_\_\_\_

WITNESSED: \_\_\_\_\_