Christian
Family Medicine

Please complete **ONE** of the following:

I, ______________________________ , give permission to the following individual(s): ____ to seek medical treatment for my child ________________________________ at Christian Family Medicine, Inc. in my absence.

OR

I, ___________________________________ , give permission for my child _______________________________ to be treated at Christian Family Medicine, Inc. alone in my absence.

____
Signature of parent/guardian

____
Date

* Valid for 1 year after date signed above