Permission to Treat

I (We), _____, authorize **Dr. Mary's Place** and its personnel to deliver medical services to my child(ren), listed below.

Name: _____ **Date of Birth**:_____

Name: _____ **Date of Birth**:_____

Name: _____ **Date of Birth**:_____

Name: _____ **Date of Birth**:_____

Name: _____ **Date of Birth**:_____

Name: _____ **Date of Birth**:_____

I (We) authorize the following people to bring my child(ren) in for treatment, and /or to contact in case of an emergency:

Name: _____ **Phone**: _____ **Relationship**: _____

Name: _____ **Phone**: _____ **Relationship**: _____

Name: _____ **Phone**: _____ **Relationship**: _____

_____ _____

Signature of Legal Guardian **Date**

_____ _____

Primary Phone **Relationship to Patient**