ARLINGTON FAMILY PRACTICE

I _____, give my consent for my minor child,
parent or legal guardian

_____, to be treated by the physician of
name of minor child/DOB

Arlington Family Practice, and if immunizations are to be administered, I Delegate

Authority to consent for immunizations and treatment to _____,
name of adult accompanying minor

_____. This consent is valid until withdrawn in writing.
relationship (grandparent, aunt, uncle, etc.)

_____
Signature of Parent or Legal Guardian

_____
Relationship

_____
Date