# Conroe Family Medicine, PA
## 690 S Loop 336 W Ste 222
## Conroe, TX 77304
## 936-756-6661

## Authorization to treat a minor

I, ________________________________ give the following person(s)
Parent/Legal Guardian
consent for medical evaluation and treatment of my

child ______________________________, DOB _______________

Name _________________________ Relationship___________________

Name _________________________ Relationship __________________

Name _________________________ Relationship __________________

Name _________________________ Relationship __________________

I understand that my signed consent is required to allow treatment of my child without personally being present and give permission to the above person to consent to any and all medical treatment.

**This authorization expires one year from date signed**

______________________________ __________
Signature of Parent/Legal Guardian Date