



VIP Kids Clinic Minor Consent Form

I _____, Parent or Legal Guardian of:

Patient Name: _____ D.O.B _____

Patient Name: _____ D.O.B _____

Patient Name: _____ D.O.B _____

Patient Name: _____ D.O.B _____

Hereby consent and authorize the following people to accompany my children to the physician's office in case of an emergency and proceed with any recommended or deemed necessary procedures.

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Signature of Parent/Legal Guardian _____ Date _____

Telephone Number: _____