Consent For Treatment Of A Minor Child

I,_____ give permission to the physician and/or nurses of Cooper Family Medical to evaluate and treat my minor child in my absence:

Minor Child's Name	Date Of birth

This is to include any emergency measures which may become necessary during the course of normal treatment.

This consent shall expire one year from today's date and supersedes all other signed minor consent forms.

Print Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

Print Witness Name	Witness Signature	Date

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