

Patient Name \_\_\_\_\_

Patient D.O.B. \_\_\_\_\_

Physician \_\_\_\_\_

I, \_\_\_\_\_, give **parental consent** for Genesys Family Medicine  
(Print Legal Guardian's Name)

to treat my child, \_\_\_\_\_, without me being present.  
(Print child's name)

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date