Sparrow Medical Group

Minor Consent to Treat

(Please print clearly and fill out entirely)

For 17 years old and younger. This will allow your child to be treated in our office in the absence of the parent/guardian.

I authorize Sparrow Medical Group to perform routine diagnostic procedures and provide medical treatment for my child if it is warranted in the professional opinion of the Physician.

I,_____ , give my permission for

_____ or _____
Print name of responsible adult Print name of responsible adult

_____ or _____
Print name of responsible adult Print name of responsible adult

To seek and obtain medical treatment for my child named below

Name of Child _____ Date of Birth_____

This consent will remain in effect from the date of the parent/legal guardian signature below or unless revoked by parent/legal guardian.

_____
Signature of Parent/Guardian Date

_____
Witnessed by Date