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## Consent to Medical Care and Treatment of Minor Children

I, \_\_\_\_\_, the natural parent/ legal guardian of: \_\_\_\_\_, authorize and consent to have the following medical care delivered in my absence at Edmonds Family Medicine Clinic.

• Allergy injections	<input type="checkbox"/>	• Suture removal	<input type="checkbox"/>
• Emergent care (sutures, casts, etc.)	<input type="checkbox"/>	• Medication Administration	<input type="checkbox"/>
• F/U care e.g.: my son or daughter may be seen without me for routine care and follow up appointments	<input type="checkbox"/>	• Immunizations	<input type="checkbox"/>
• School and/or sports	X	• X-rays	<input type="checkbox"/>
		• Laboratory studies	<input type="checkbox"/>

I hereby agree to accept responsibility for any financial indebtedness incurred, at the physicians' office. I agree to pay all necessary services at the current rate.

Child's Name: \_\_\_\_\_ (print)

Parent/Guardian: \_\_\_\_\_ (signature)

Witness: \_\_\_\_\_ (signature)

Date effective: \_\_\_\_\_ Date expired: \_\_\_\_\_

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Board Certified American Board of Family Medicine

### Walk-in-Clinic Hours:

Monday—Friday 9am-8pm  
Saturday & Sunday 9am-4pm  
www.psfp.net

Member of Puget Sound Family Physicians

*Empowering people to lead healthier lives*