EFM
EDMONDS FAMILY MEDICINE

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

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:_____