HARRISONBURG FAMILY PRACTICE
1831 RESERVOIR STREET
HARRISONBURG, VA 22801
PHONE 540-433-9151
FAX 540-433-0547

PERMISSION FOR MEDICAL TREATMENT FOR MINORS

I/WE____

(PARENTS/LEGAL GUARDIAN) CELL#_______________________________

GIVE PERMISSION FOR PERSON(S) TO BRING MINOR:

____

(FIRST & LAST NAMES OF PERSON BRINGING MINOR FOR MEDICAL ATTENTION)

____

(FIRST & LAST NAMES OF PERSON BRINGING MINOR FOR MEDICAL ATTENTION)

MINOR RECEIVING MEDICAL TREATMENT AT
HARRISONBURG FAMILY PRACTICE:

NAME:_______________________________________ **DOB:**_____________

NAME:_______________________________________ **DOB:**_____________

NAME:_______________________________________ **DOB:**_____________

NAME:_______________________________________ **DOB:**_____________

NAME:_______________________________________ **DOB:**_____________

****

PARENT(S), GUARDIAN(S) SIGNATURES:

____DATE:______________

____DATE:______________