CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

Consent to Provide Treatment for Minor Children

Child's name _____

Child's Birth Date _____

Parent's/Guardian's Name(s) _____

Contact phone number _____ (work) _____ (home)

Home address _____

I (we) the parent(s) or guardian(s) of the child named above, consent to any necessary examination, medical diagnosis, treatment and/or care to be rendered to the above-named minor child under the general or special supervision and on the advice of any health care professional. I (we) agree to pay for all services provided to my child in my absence.

Parent or Guardian _____ (print)

Parent or Guardian _____ (sign)

Date _____

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