SAVING GRACE HEALTH

AUTHORIZATION FOR TREATMENT OF A MINOR

Child's Name (First, Middle, and Last): _____ DOB: _____

I, (Parent/Guardian) _____, do hereby give permission for medical treatment from a provider at Saving Grace Pediatric Concierge of (Child's Name) _____ .

The following person(s) have my permission to have the children listed above treated by Saving Grace Pediatric Concierge:

1. (First, Middle, and Last): _____

2. (First, Middle, and Last): _____

3. (First, Middle, and Last): _____

4. (First, Middle, and Last): _____

Parent/Guardian Name: _____ Date: _____ Signature: _____