

AUTHORIZATION TO TREAT MINOR

Name of Child/Minor

Name of Physician

As the parent/guardian of the above-named child/minor, I hereby give permission to Family Care Associates of Effingham, S.C. to treat the child/minor in the event that a medical emergency arises and/or I am unable to personally consent to the treatment. I also agree to be responsible to the physician for charges for medical services rendered.

Parent or Guardian's Name (Print Please)

Date

Parent or Guardian's Signature