Family Medical Center
at
Cinco Ranch

23144 Westheimer Parkway * Katy, TX 77494 * Office 281.392.5005 * Fax 281.392.5052

CONSENT FOR PROXY TO SEEK TREATMENT OF A MINOR IN THE ABSENCE OF PARENT/LEGAL GUARDIAN

_____ __ __/__ __/__ __ __ __

Minor's Name in Full Date of Birth

I, _____,
the undersigned parent/legal guardian of the above stated minor, do grant permission for _____ to seek medical care for this minor in the absence of a parent or legal guardian. This individual has full permission to consent to all health services, including but not limited to: examination, preventative and/or curative treatment, vaccination, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guradian(s), or until child may legally consent for him or herself.

_____ _____

Signature - Parent or Legal Guardian Date

_____

Print Name and Relationship