Consent for Treatment of Minor Child

I, being the parent or guardian of ___________________________________, born ______________, do hereby request and authorize Dr. Boyd or Debbie Sherman, PA-C and his/her staff to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

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Parent or Guardian Name

____
Parent or Guardian Signature

____
Date

____
Witness Name

____
Witness Signature

____
Date

Dale W. Boyd, Jr., MD | Debbie Sherman, PA-C

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