



Parental Authorization for Medical Services

I hereby give authorization for my child to be seen by the physician without a parent or legal guardian present.

I authorize the physician to do a medical examination and perform appropriate non-invasive treatment, including x-rays, and report the findings and treatment plan to me.

I hereby state that my child's immunizations are up to date.

Printed Minor's Name _____

Authorized by _____ Date _____
Signature of Parent or Legal Guardian

Printed Parent or Legal Guardian Name _____