CONSENT TO TREAT MINOR

I, _______________________________________, as parent or legal guardian of minor child,
(Please Print Full Name)

____________________________________, do hereby provide my consent to Eagles Landing
(Please Print Full Name)

Family Practice, LLC dba Eagles Landing Health ("ELH") to perform any medical evaluation or treatment determined by ELH to be necessary for the welfare of my minor child if I am not present or reasonably available by telephone to provide consent. This authorization is effective from the date below.

I agree to assume full financial responsibility for all charges incurred resulting from any medical evaluation and treatment regardless of insurance assignment. This consent will remain in effect until I revoke it by providing ELH written notification.

____________________________________ ____________________________
(Signature of Legal Guardian) (Date)

____________________________________ ______________________________
(Signature of Witness) (Witness Print Name)

Address of Legal Guardian: ____

Father's Telephone: ______________________ Mother's Telephone: __________________________

Minor Child Date of Birth: ____

Special Medications, Allergies or Pertinent Information: _____________________________________

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