CONSENT TO TREAT

MY CHILD (FULL NAME)_____, D.O.B._____

HAS AN APPOINTMENT FOR A PHYSICAL ON (DATE) _____ AT THE OFFICE OF CHILDREN'S CLINIC OF WYOMISSING.

I GIVE MY PERMISSION TO TREAT MY CHILD WITH A TRATMENT PLAN AND VACCINATION THEY DEEM NECESSERY AND APPROPRIATE.

_____ _____

FULL NAME OF PARENT OR LEGAL GUARDIAN RELATIONSHIP TO THE CHILD

_____ _____

SIGNATURE DATE