HOPE419

PERMISSION TO OBTAIN MEDICAL TREATMENT WHEN A PARENT OR GUARDIAN IS NOT PRESENT

I/We ____
(parent(s)/guardian(s) first and last names)

give my/our permission for ____
(first and last name of adult authorized to obtain care)

to seek medical attention at Hope419 and receive treatment for my/our child(ren):

Name: ________________________________ DOB: _______________________

Name: ________________________________ DOB: _______________________

Name: ________________________________ DOB: _______________________

I/We can be reached at __________________________ during office hours, if needed.

Parent/Guardian Signature ____________________________________ Date__________

Parent/Guardian Signature ____________________________________ Date__________