Entira FAMILY CLINICS
Where generations thrive

PARENTAL CONSENT FORM

TREATMENT OF A MINOR

Authorization is hereby given to Entira Family Clinics to provide medical care for_____ _____/_____/_____.
(minor's name) (date of birth)

This form is valid for the treatment of _____
for the following date(s) of service: _____ **OR** _____ to _____.
(specific date) (date) (date)

I may be reached at _____ for verification.
(phone number)

_____ _____ _____
Signature of Parent/Legal Guardian Relationship Date

***** Once patient reaches the age of majority this document becomes null and void*****

Scan document in Health directive folder: _ _ / _ _ / _ _ _ _ Parental Consent Form