Kids Creek Children's Clinic
Fax: 231-935-0562

Consent for Treatment

Consent for patients being brought to the office by someone other than the parent or legal guardian.

I, the parent or legal guardian of _____hereby

authorize _____
(name and relationship to patient)
to bring my child to the office for evaluation and treatment including any needed procedures and immunizations. I have provided the above named with the necessary health history for my child.

This authorization is in effect until one year from this date, unless revoked by me in writing prior to one year.

Parent/Legal Guardian Signature: Date

I will be available at the following phone number(s) should the office staff need to contact me:

1. ( ) _____

2. ( ) _____