

**CONSENT FOR TREATMENT
OF A MINOR CHILD**

I do hereby state that I am the parent or legal guardian of _____

a minor, age _____ who resides with me at _____

I give permission for:

Any necessary examination, x-ray, anesthetic, medical or surgical diagnosis, treatment, casting, splinting, injections, aspirations, MRI or DME products to be provided or rendered to the above named minor under general or special supervision and on the advice of any physician or physician assistant licensed to practice medicine in the State of Texas. I also give authorization for the patient to sign any legal document in my absence.

Signature of parent or guardian : _____

Signature of adult witness: _____