

OAKHURST MEDICAL CENTERS, INC.
MINOR/CHILD CONSENT

I _____ certify that I am the legal parent,
Parent Name (Print)
guardian, or personal representative of _____
Minor/Childs Name *Date of Birth*

I do hereby request and authorize the following individuals to bring my child to Oakhurst Medical Centers in the event that I am not able to do so.

_____ <i>Authorized Individual</i>	_____ <i>Relationship to Child</i>
_____ <i>Authorized Individual</i>	_____ <i>Relationship to Child</i>
_____ <i>Authorized Individual</i>	_____ <i>Relationship to Child</i>
_____ <i>Authorized Individual</i>	_____ <i>Relationship to Child</i>

I certify that there are no court orders now in effect that prohibit me from signing this consent. I also authorize the physicians and Oakhurst Medical Centers, Inc. clinical staff to perform necessary services for the child named above, including but not limited to x-rays, and treatment, which are deemed advisable by the physician, whether or not I am present when the treatment is rendered.

Parent Signature

Date

MR#: _____