Consent to Treat

I am the parent or legal guardian of the child named below. I give Franklin Pediatric Associates and its providers and staff permission to examine, test, vaccinate, and treat my child. I understand I can ask questions about any care before it is given, and that I may withdraw this consent in writing at any time.

Child's full name: _____ Date of birth: _____

Parent/Guardian signature _____

Printed name: _____

Relationship to child: _____

Date: _____