Oregon City Family Practice Clinic, P.C.

MINOR MEDICAL RELEASE FORM

Parent must present at child's first visit

I, _____(Parent/Guardian's Name) hereby give permission for any and all medical treatment to be administered as the doctor deems necessary to my child, _____(Child's Name) by Oregon City Family Practice Clinic, PC in the event of accident, injury, sickness, etc. under the direction of the person(s) listed below:

Name(s):_____ Relationship to minor:_____

OR

I, _____(Parent/Guardian's Name) hereby give permission for any and all medical treatment to be administered as the doctor deems necessary to my child, _____(Child's Name) by Oregon City Family Practice Clinic, PC in the event of accident, injury, sickness, etc. My child is _____years old and I give him/her permission to seek treatment on their own accord without myself or their other parent/guardian being present.

I assume the responsibility for the payment of any and all treatment by Oregon City Family Practice Clinic, PC.

I can be reached at:

_____ (cell home work) please circle one

OR

_____ (cell home work) please circle one

Primary Care Physician (required):

Name: _____ Office phone #: _____

Allergies: _____

Current Medications: _____

This release is effective for the period of one year from the date given below.

Signature of Parent/Guardian: _____ Printed Name: _____

Date: _____

Signature of Witness: _____ Printed Name: _____