320 Park Avenue, P.O. Box 517, Boca Grande, Florida 33921
Telephone: 941-964-2276 ⬧ Fax: 941-964-0158 ⬧ www.bghc.org

CONSENT TO TREAT MINOR CHILDREN

(Please print all information)

I, ____, parent or legal guardian

(Parent/Guardian Name)

of ____, born ________________________,

(Minor Child's Name) (Minor Child's Date of Birth)

do hereby consent to the evaluation and any medical care or treatment necessary for the welfare of my child while said child is under the care of the Boca Grande Health Clinic Physicians and staff.

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Signature of Parent/Legal Guardian Date