Consent to Treat a Minor Child

I hereby authorize Dr. Sullivan and associates to treat my son/daughter as necessary, when chaperoned by a designated adult relative, adult babysitter or adult family friend as listed below. Drivers License of supervising adult is required at each visit.

Name of Child: _____

Date of birth: _____ Parent cell phone:_____

Parent name:_____

Names of Adult Chaperones _____

_____

_____

_____

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____Date:_____