CONSENT FOR MEDICAL TREATMENT OF MINORS

Southwest Family Physicians, Inc.
Affiliated with Southwest General Medical Group, Inc.
7225 Old Oak Blvd., Suite A210
Middleburg Heights, Ohio 44130

Name: _____

Address: _____

_____

Phone: Father/Work: _____

Mother/Work: _____

Home: _____ Other: _____

In the event that I am unavailable, I hereby give my consent to Southwest Family Physicians, Inc. affiliated with Southwest General Medical Group, to provide whatever medical treatment Southwest Family Physicians, Inc. determines is necessary for my child. I agree to be responsible for any bill incurred by my child.

Child's Name: _____ DOB: _____

In case of emergency, if it is not possible to contact me (us) please notify:

Name: _____

Address: _____

Phone: _____

Relationship to minor: _____

Signed: _____
(Parent Signature or Legal Guardian)

Date: _____ Valid until: _____