



Willow Bend Pediatrics

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Permission to Treat Form

Date: _____

To Whom It May Concern:

I, _____, guardian of _____ give
(Parent's Name) (Child's Name)

my permission for _____ to seek medical care and make

medical decisions as necessary on my behalf from _____ to _____.

Parent's Signature

Print Name

Date

WBP Witness Signature

Print Name

Date