Minor Permission Form

Child's name: _____ Child's Date of Birth: _____

I, _____, parent/legal guardian of _____

(Patient name)

grant providers of Fox Valley Family Physicians to meet with and administer any necessary medical

care/immunizations for _____on _____/_____/_____

(Patient name) (Date)

This shall remain in effective until _____/_____/_____

(Date)

_____Parent /legal guardian

(Signature)

_____Parent/legal guardian

(Printed name)