Seven Hills Pediatrics

6853 Coit Rd.

Plano,TX 75024

Phone #: 469-543-0630

Fax: 469-543-0620

Consent for Minor Care

I _____, give permission for:

(Parent's Name)

_____ _____

(Name) (Relationship to child)

_____ _____

(Name) (Relationship to child)

To bring my child, _____, for his/her appointments and make decisions in my absence.

I authorize Seven Hills Pediatrics to render medical care to my child.

Please give them any instructions and/or prescription that may be needed.

In case of an emergency, I can be reached at _____.

(Contact Number)