UNIFOUR FAMILY PRACTICE

2874 NC HWY 127 SOUTH

HICKORY, NC 28602

828-294-4100

828-294-4112

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PARENTAL CONSENT FORM

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_being the parent/guardian

OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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child/children under the age of 18 years of age, give my permission for the healthcare providers at Unifour Family Practice to treat the above-named child/children for whatever condition the providers considers necessary in the event I am unable to accompany my child/children at the time of the appointment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

Please list the name/names of anyone who may bring your child to our office for his/her appointment in the event that parent/guardian is unable to do so.

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