CONSENT FOR MEDICAL TREATMENT OF A MINOR

In my absence, I, the undersigned parent/guardian hereby grant Health Concepts at 5410 Sheridan Lake Road, Rapid City, SD 57702 permission for medical treatment of my child.

I agree to assume financial responsibility for all expenses of medical care.

This grant of temporary authority shall begin on _____ (date) and remain effective until terminated by the undersigned.

Name of Child	DOB	Allergies/Medications

Parent/Legal Guardian Signature: _____Date:_____

Witness Signature:_____Date:_____