Caring for Women's Health

Lori L. Davidson, MD, FACOG
107 N. State Road 135, Suite 102
Greenwood, IN 46142

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, (We) ________________________________and _____________________________________
Name of Parent *Name of 2nd Parent, if applicable*
Of (City) ________________________ (State) _____, do hereby state that I am (we are) the

parent(s) or legal guardian(s) of ____,

a minor, age ___________, born ____ /____ /____

Who resides with me (us) at this address:

____

____

I, (We) authorize ____________________________ as a parent or guardian to consent to
Name of Child
Any necessary physical examination, pelvic exam, anesthetic, medical or special
Supervision and treatment. Upon the advice of the above provider or surgeon licensed
To practice medicine in the State of Indiana.

Dated this _______ day of ______________ in the year _________.

________________________________ _________________________________
Signature of Parent *Signature of Witness*