# CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT OR GUARDIAN

I give my permission and written consent to Frankenmuth Medical Associates, its practitioners, employees, agents and partners to render any and all medical treatment deemed necessary to my child(ren) listed below in my absence.

_____ _____

_____ _____

_____ _____

_____ _____

**Please select one:**

- ❑ This permission applies to whomever accompanies my child(ren) to the office.
- ❑ My child (age 16, 17 or 18) has my permission to be seen unaccompanied.
- ❑ This permission applies only to the people listed below:

_____

_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date

If the patient is under 18 years of age, his or her consent is acceptable for these reasons:

❑ Married ❑ High School Graduate ❑ Pregnancy/Birth