



Muskegon Family Care
2201 S. Getty Street
Muskegon Heights, MI 49444
Phone 231-739-9315
Fax 231-733-3195

Authorization for Medical Treatment of Minors

Please only list one minor patient per form. This form is not valid without a Parent/Guardian signature

Name of Minor: _____ Date of Birth: _____

Please read carefully

I (We), the undersigned, being the Parent/Legal Guardian(s) of the above named minor, give medical care personnel at Muskegon Family Care permission, in my absence, to examine, order laboratory, administer medications, immunizations, fluoride treatments, sealants and provide other care as is deemed necessary, regarding the minor child listed above.

This permission extends to visits when the following person(s) bring my child to the clinic:

Name of Authorized Person: _____ Address: _____ Phone: _____

Name of Authorized Person: _____ Address: _____ Phone: _____

This permission authorization shall be effective:

Start Date: _____ Through Date: _____ or until canceled.

**Parent/Guardian Name: _____

Address: _____ Phone: _____

Email: _____

Parent/Guardian Signature: _____ Date: _____

Court documentation for any change in custody or guardianship must be presented at the time of office visit