Dover Family Physicians, PA

1342 South Governors Ave

Dover, DE 19904

(302) 734-2500

I, _____ give permission to the doctors and/or nurses of

(Parent's name)

Dover Family Physicians, PA to treat my minor child _____

(Child's name)

in my absence. This is to include any emergency measures which may become necessary in the course of normal treatment.

_____ _____

(Parent's signature) (Date)

_____ _____

(Witness) (Date)