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MEDICAL CONSENT FOR MINOR CHILD

I, _____, the parent or legal guardian of
_____, DOB _____ do hereby consent and allow the
following individuals to make medical care decisions for my child including but not
limited to the administration of vaccines, labs, blood work or any other care recommended
or deemed necessary for the welfare of my child determined by a physician.

This authorization is effective on this ____ day of _____, 20____ and will expire 366 days from this date.

Parent signature:

_____ Date: _____