



# Benton Pediatrics, Inc.

Board Certified Pediatrics

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Modified 9/18/07

## Consent to Obtain Medical Treatment

Patient's Full Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Name of person filling out form: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I, \_\_\_\_\_

give my consent to allow \_\_\_\_\_

to obtain medical care and/or treatment for my child,

\_\_\_\_\_.

This consent will be valid from \_\_\_\_\_  
(Effective Date)

until \_\_\_\_\_  
(no more than one year)

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_