LAKE COUNTY FAMILY PRACTICE
CONSENT TO MEDICAL TREATMENT
PERMISSION TO TRANSPORT

Patient Name_______________________________________ **Billing ID** _________

I, ____, give Lake County Family Practice my consent to administer medical treatment for my child, ___________________________________and permission to transport, if necessary, to any Lake Health facility or tertiary facility as required.

_________________________________ __________________________________ ____________
(Parent/Legal Guardian's Signature) (Relationship to Patient) (Date)

PARENT / LEGAL GUARDIAN
INFORMATION

Name____ ____________________
(Last) (First) (Home Phone)

Address____
(Street) (City) (State) (Zip)

______________________________________ ____________________ ________________
(Place of Employment) (Work Phone) (Cell Phone)

ACCOMPANIED TO OFFICE BY
(If other than parent/legal guardian)

Name_____ ___________________
(Last) (First) (Home Phone)

Address____
(Street) (City) (State) (Zip)

____
(Relationship to Patient)