Kinship Letter to Treat

Date:

To whom it may concern:

I, _____ parent / legal guardian of

_____ , Date of Birth
(child's name)

_____ , Date of Birth
(child's name)

_____ , Date of Birth
(child's name)

give permission for _____
(name of adult designee)

to bring my child/children for medical appointments and to give consent and sign any and all necessary documents or forms on my behalf in order to allow any examination, treatment, testing, surgery or care as recommended by a physician/ARNP licensed to practice medicine in the State of Florida.

_____
Parent / Legal Guardian Signature

_____
Notary signature

Memorial Healthcare System

PATIENT/LABEL