

**PARENT/GUARDIAN CONSENT  
FOR TREATMENT OR EXAMINATION**

As the parent and/or legal guardian of \_\_\_\_\_, a minor,  
I give my permission to Dr. Stephen Stanley for a physical examination and/or treatment  
as determined to be needed by the physician.

_____	_____
PATIENT NAME	DATE
_____	_____
PARENT/GUARDIAN NAME	DATE
_____	_____
WITNESS	DATE