

**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