SAN DIMAS FAMILY CARE, INC.

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I hereby authorize San Dimas Family Care, Inc. to provide medical examination and treatment to:

Name of Minor:____
(Please Print Clearly)

Date of Birth of Minor:___________________________________

I further authorize San Dimas Family Care, Inc. to prescribe, order x-ray and/or laboratory examinations, or other ancillary services deemed advisable.

____________________________________	________________________
Name of Parent or Legal Guardian (Please Print Clearly)	Relationship
____________________________________	________________________
Signature	Date: