CONSENT TO TREAT

I give consent for ______________________________________ to seek medical care as indicated below for my child(ren), ______________________________________ from CHILDREN'S HEALTH CARE CENTER OF NORTHERN VIRGINIA.

This consent is valid for one year from date of consent.

_____ Urgent Sick Care

_____ Emergency Care

_____ Immunizations

_____ Allergy Shots

_____ Preventative Care

CONTACT INFORMATION: In case the provider needs to speak directly with you.

Mom daytime phone: ____________________ Dad daytime phone: ____________________

Parent/ legal guardian PRINTED name	Signature	Date