Franklin Primary Health Center, Inc.
(FPHC)

PERMISSION FORM

I _____ understand that by signing this authorization, I am agreeing that only the persons indicated below can seek or authorize medical treatment for my child/dependent.

1. Name: _____

   Address: _____

   Relationship: _____

2. Name: _____

   Address: _____

   Relationship: _____

3. Name: _____

   Address: _____

   Relationship: _____

_____ _____
Signature Parent/Guardian Date

_____ _____
Witness Date

Rev: 11/06