



**Your Wellness Connection of Leawood**

11401 Ash / Shawnee Mission, KS 66211  
Phone (913) 962-7408 Fax (913) 962-7416

**Consent to Treatment of Minor Child**

I, (print parent/guardian name) \_\_\_\_\_ hereby authorize  
Dr. \_\_\_\_\_ and whomever she/he may designate in  
assistance to administer treatment as deemed necessary to my (son/daughter)  
\_\_\_\_\_, (print child's name) \_\_\_\_\_.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Witnessed: \_\_\_\_\_