Consent to Treat Minor

I, _____ , as parent or legal guardian of minor child,
PLEASE PRINT FULL NAME

_____ , do hereby provide my consent to Aylo Health, LLC
PLEASE PRINT FULL NAME

to perform any medical evaluation or treatment determined by Aylo Health to be necessary for the welfare of my minor child if I am not present or reasonably available by telephone to provide consent. This authorization is effective from the date below.

I agree to assume full financial responsibility for all charges incurred resulting from any medical evaluation and treatment regardless of insurance assignment. This consent will remain in effect until I revoke it by providing Aylo Health written notification.

Signature of Legal Guardian: _____ **Date:** _____

Signature of Witness: _____ **Print Witness Name:** _____

Address of Legal Guardian: _____
CITY STATE ZIP CODE

Father's Telephone: _____ **Mother's Telephone:** _____

Minor Child Date of Birth: _____

Special Medications, Allergies or Pertinent Information: _____

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