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) (Witness Print Name)

Address of Legal Guardian: ____

Father's Telephone: ________________________ Mother's Telephone: ____________________________

Minor Child Date of Birth: ____

Special Medications, Allergies or Pertinent Information: ____

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