



FAIRFAX FAMILY PRACTICE  
*A VCU Academic Center*  
3650 Joseph Siewick Drive  
Suite 400  
Fairfax, VA 22033  
703-391-2035

I, \_\_\_\_\_ give permission to the doctors and/or nurses of  
(Parent's name)

Fairfax Family Practice to treat my minor child \_\_\_\_\_  
(Child's name)

in my absence. This is to include any emergency measures which may become necessary in the course of normal treatment.

\_\_\_\_\_  
(Parent's signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness' signature)

\_\_\_\_\_  
(Date)