



**Lawrence E. Foltz, D.O., FAAFP**  
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I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_.

Authorize and consent to routine and emergency medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date Signed