WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE

Permission to Treat Minor Child

Child's Name:_____ **Date of Birth**: _____

I hereby give my permission for WMed staff to treat my minor child, in the presence of the following individuals listed with relationship:

_____, _____.
Name Relationship

_____, _____.
Name Relationship

I understand that this release is only for the above mentioned person(s). If for any reason I no longer wish for the above mentioned person(s) to be able to bring my child in for medical treatment, I will complete a new release identifying only the appropriate individuals.

_____I **do** authorize the administration of vaccines.

_____I **do not** authorize the administration of vaccines.

_____ _____
Signature of the parent or guardian **Date of signature**

_____ _____
Signature of witness **Date of signature**
