Beth Gallant, D.O.

Greg Gallant, Clinic Manager
2589 NW Edenbower Blvd
Roseburg, OR 97471
Phone: (541)677-6116
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Consent to Treat

I, ___________________________, the legal parent or guardian of

1. ____,
   Name and date of birth

2. ____,
   Name and date of birth

3. ____,
   Name and date of birth

4. ____,
   Name and date of birth

hereby authorize the individuals listed below to consent on my behalf to any necessary medical treatment, examination, injections, immunizations, or diagnostic procedures for the children listed above. This will remain in effect for 1 year from the date signed.

_________________________________ _____________
Signature Date

Authorized individuals and relationship, listed below.

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____
____
____