PLEASE COMPLETE THIS FORM AND RETURN TO:

Sage Medical Group, S.C

916 South Wabash Ave. #503

Chicago, IL 60605

TEL: 312-369-6830

FAX: 312-360-1762

CONSENT TO TREATMENT OF A MINOR

I hereby consent for and on the behalf of my minor son/daughter/ward, ____________________ to the performance of any and all treatment for illness or injury by Sage Medical Group,. S.C of Chicago.

I hereby inform Sage Medical Group S.C of Chicago that to my knowledge, __________________ has allergies to the following drugs:

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

______________________________ ______________________________

Signature of Consenting Date

____

Relationship to minor

Address: ______________________________

____

Phone number: ______________________________