



Pierre G. Labrecque, M.D.  
120 North Miller Street, Building C  
Santa Maria, CA 93454

**CONSENT FOR TREATMENT OF A MINOR**

As the parent/legal guardian of \_\_\_\_\_,  
I hereby consent to and authorize the administration of all treatments that may be considered  
advisable and necessary in the judgment of the physician. I consent to X-ray examinations,  
laboratory procedures, medical treatment, EKG or services rendered under the instructions of the  
physician. I understand that I am financially responsible to the physician. I authorize payment of  
all medical benefits to the physician.

I here certify that the above information is true and correct to the best of my knowledge.

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_