

Rocky Creek Family Medicine

Deirdre McMullen M.D. Hillary Spears FNP Jackie Alfaro FNP

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Consent for Treatment of Minor With or Without Adult Present

I, _____, give Dr. McMullen, Hillary Spears FNP or Jackie
(Parent/Guardian-please print name) Alfaro FNP permission to treat my minor child,

(Patient name – please print)

(Date of Birth)

- without my presence or presence of an adult.
- with an adult of whom I give permission.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand that this letter can be revoked at any time. If there should be a
medical emergency, I can be reached at (_____) _____ - _____.

Parent/Guardian Signature

Date