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I, _____, being the legal guardian of _____,
do hereby give my permission for him/her to be evaluated and/or receive treatment by Donald J. Rose, M.D.

Name of Patient _____

Name of Guardian _____

Signature of Guardian _____

Date _____

Please fill in the following information:

Mother's Name _____

Father's Name _____

Address _____

Address _____

Phone H: _____ W: _____

Phone H: _____ W: _____