Adolescent Health Consent for Medical Treatment

Date: [Insert Date]

To Whom It May Concern,

I, [Parent/Guardian Name], am the [Parent/Guardian] of [Adolescent's Name], born on [Adolescent's Date of Birth].

I hereby give my consent for my adolescent child to receive medical treatment as recommended by the healthcare provider. This includes, but is not limited to, physical examinations, vaccinations, diagnostic tests, and any necessary treatment.

I understand that I will be informed of any significant findings or tests performed during the course of treatment. In case of emergencies, I authorize the healthcare provider to act in the best interest of my child.

Should you need to contact me for further information or clarification, please feel free to reach me at [Parent/Guardian Phone Number] or [Parent/Guardian Email Address].

Thank you for your attention to this matter.

Sincerely,

[Parent/Guardian Name]

[Parent/Guardian Signature]

[Address]