

**Dr. B. Mark Vance, MD**

**Vance Medical  
1001 North Meridian Rd.  
Meridian, ID 83642  
208-227-8146  
info@vancemedical.com**

**Consent for Treatment For Minors**

**I authorize Dr. B. Mark Vance, MD, to provide medical care for:**

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**Child's Name** **Date of Birth**

**I certify that I am this child's parent or legal guardian with full rights to give this authorization and I agree to be responsible for the cost of this treatment at the time of service.**

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**Signature** **Date**