Lisa B. David, MD Brytton B. Eldredge, MD
109 Rue Fontaine
Lafayette, LA 70508
(337) 266-9820 (337) 266-9822 (fax)

Consent for treatment of a minor

Patient Name: ________________________________ DOB: _________ Date: _______

I, ____, authorize the individual(s)
(name of parent or legal guardian – Please print)

listed below to bring my child, ____, into the offices of Dr. Lisa B. David and Dr. Brytton Baker Eldredge to receive medical care. I realize I am granting these individuals the authorization to make medical decisions, excluding authorization for surgery on my behalf. This authorization is good for a period of 1 (one) year from the date on this form or until a written revocation is issued to our office by a parent or a legal guardian.

Name: ____ Relationship: ___________
Name: ____ Relationship: ___________
Name: ____ Relationship: ___________
Name: ____ Relationship: ___________
Name: ____ Relationship: ___________

Please be aware that anyone not listed above, besides the parent or legal guardian (must have documentation to prove legal guardianship), does not have the authority to bring in the above mentioned patient.

Signature: ____ Date: _______________