ABOUNDING HOPE
HEALTH OPTIONS

3050 W 151St Ct.
Suite 100
Broomfield, CO 80023
www.aboundinghope.life

(303) 494-3116 Office

Child/Guardian Permission Form

Date: _____

Client: _____

Guardian/Parent Name: _____

I do hereby give permission for my under 18-year-old child to be seen by Kerry Sprague and Abounding Hope Health Options, without my presence in the office. I will and do assume all responsibility for my child and understand that he/she may be brought by a child care provider or drive themselves and may receive treatment deemed necessary by Kerry Sprague and Abounding Hope Health Options.

_____

Parent/Guardian Signature