**** 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abounding Hope Health Options Signature