



HARRIS  
MEDICAL CENTER

**PARENTAL CONSENT FOR PHYSICAL EXAMINATION**

I do hereby certify that I am a parent, legal guardian, or other legal representative with the authority to make medical decisions on behalf of \_\_\_\_\_ (the Student) and, in accordance with that authority, I do hereby give consent for the physical examination of the Student by any of the qualified practitioners providing services through Unity Health Harris Medical Center.

\_\_\_\_\_  
Parent/Guardian/Authorized Representative Signature      Date

\_\_\_\_\_  
Name of Parent/Guardian/Authorized Representative (please print)

\_\_\_\_\_  
Address of Parent/Guardian/Authorized Representative

\_\_\_\_\_  
Daytime Phone Number for Parent/Guardian/Authorized Representative

\_\_\_\_\_  
Witness Signature