



PARENTAL CONSENT FORM

I, _____ give my parental consent to a La Porte Regional
Parent/Guardian Name (Printed)

Physician Network Physician/Nurse Practitioner to perform a Sports Physical on my child,

Child's Name (Printed)

My child's family physician is: _____

Parent or Guardian Signature

Date

Witness

Date



WAIVER TO BILL INSURANCE FORM

I, _____ want to take advantage of the special discounted
Parent/Guardian Name (Printed)

Service for a Sports Physical for my child, _____ and agree to pay \$25.00 at
time of service. By taking advantage of this special discounted service, I agree that I am waiving
for this service to be billed to my insurance company.

Responsible Party Signature

Date

Witness

Date