G#_____

WOMEN'S HEALTH ADVANTAGE

Weight Loss Program for a Minor
Consent and Waiver

Patient Name_____ DOB_____ Age_____

Date patient will be 18 years old ____/____/_____

I, _____, the parent or legal guardian of _____
(Name of parent/guardian) (Name of patient/minor)

understand that she/he is considered a minor by the state of Indiana. I hereby give consent for Women's Health Advantage to see _____ for weekly weigh-ins.
(Name of patient/minor)

I waive my rights to be present at these visits. This waiver shall be valid until the patient attains the legal age of 18.

Parent or Guardian Signature_____

Parent or Guardian Printed Name_____

Date_____/_____/_____