Aspire Health Options

669 W 100th Ave
Denver, CO 80260
(720) 999-0002
www.aspirehealthoptions.com

Child/Guardian Permission Form

Date: _____

Client: _____

Guardian/Parent Name: _____

I do hereby give permission for my child who is under the age of 18 to be seen by Sher Stout and Aspire Health Options LLC in order to identify the location for SAAT allergy treatment. I also give permission for my child who is under 18 to be treated by independent licensed acupuncturist.

I give my permission for my child who is under 18 to be seen with or 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 Sher Stout and Aspire Health Options LLC.

_____

Parent/Guardian Signature