Instant Medical Care
I Care Clinic
I Care Healing & Wellness Center
3262 Vineland Road, Unit 102, Kissimmee, FL 34746, Phone: 407-397-8937, FAX: 407-397-9547

Date: _____ Patient Name: _____

I, the undersigned parent/ guardian of _____, a minor, do hereby authorize and direct _____, MD and staff of I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center to provide ongoing routine and emergency health care to _____. This consent shall remain in effect until _____ or until revoked in writing.

I, _____, do hereby authorized and direct _____, MD and the staff of I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center to provide ongoing routine and emergency health care. This consent shall remain in effective until _____ or until revoked in writing.

For the purpose of: ☐ Injections ☐ Immunization Shot ☐ Incision and Drainage ☐ Laceration Repair

☐ Other: _____

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedures have been explained to me as well the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurances has been given by anyone as to the results that may be obtained from this procedure.

_____ _____

Patient or Parent /Guardian Signature Witness

_____ _____

Relationship to Patient Date