

Parental Consent Form

Minor's Name: _____

Please Print

Permission is hereby granted for my minor child named above to receive the following health exams as required by Medical City Fort Worth:

_____ Yearly PPD TB Skin Test

_____ Lab testing of blood following occupational exposure

_____ Background check

_____ Urinalysis for Drug Screen

_____ Yearly Influenza Shot

_____ Lab titers (current immunization records will be accepted in lieu of this, but must be presented in advance)

Signature of Parent or Guardian

Date

900 Eighth Avenue | Fort Worth, Texas | 817.347.1436 | MedicalCityHealth.com