[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title/Position]
[Medical Facility/Provider's Name]
[Facility Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I, [Your Name], as the parent/guardian of [Child's Full Name], born on [Child's Date of Birth], hereby give my permission for my child to receive medical treatment at [Medical Facility/Provider's Name].

I authorize the medical professionals at [Medical Facility/Provider's Name] to perform any necessary procedures or treatments that may be required. This permission includes, but is not limited to, diagnostic tests, medical examinations, and any necessary procedures related to [describe the type of treatment needed, e.g., minor surgery, vaccination, etc.].

I understand that I will be notified of any significant changes in my child's condition and any further treatments that may be required. Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you need any additional information or clarification.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Relationship to Child]