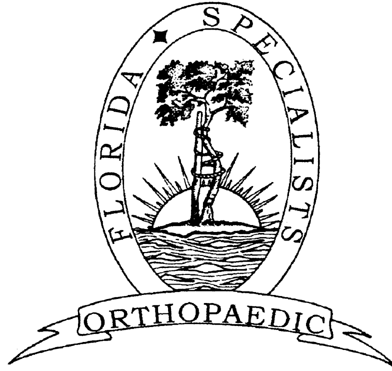
Acct #: ______________



Consent for Treatment of a Minor

Minor's Name: ____

Person completing paperwork / Relationship to Patient:	Date of Birth:	Soc. Sec. #:
Employer:	Work Phone #:	

I hereby authorize Florida Orthopaedic Specialists and its medical personnel to treat my minor son/daughter as needed.

In the event that I am unable to accompany my child to any appointment, I give permission for the following individual(s) (18 years of age and older) to act on my behalf in any medical treatment decisions.

Name:	Relationship to Patient:
____	____________________________________
____	____________________________________
____	____________________________________

Parent/Guardian Signature: ___________________________________ Date: ________________