Voytik Center *for* Orthopedic Care

Consent to Treatment of a Minor

The undersigned parent or legal guardian of _____ _____
(Child's Name) Date of Birth
authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person or by a telephone call to _____.
(Phone Number)
It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

Name of Parent or Legal Guardian: _____Relationship to Child: _____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Parent or Legal
Guardian Signature: _____ Date: _____
This Consent is effective until withdrawn in writing by the child's parent or guardian.