

AUTHORIZATION TO TREAT A MINOR CHILD IN ABSENCE
OF A PARENT OR LEGAL GUARDIAN

Please check one of the following:

The minor child under my legal care is 15-17 years of age, and I give my consent for him/her to attend an **unaccompanied** appointment. In addition, I give my consent for medical care as described below.

The minor child under my legal care is under 15 years of age, and I give my consent to him/her to attend an appointment **accompanied by an adult representative greater than 18 years of age** as designated below. In addition, I give my consent for medical care as described below.

I, _____, the parent or legal guardian of
(Name of Parent or Legal Guardian)

_____, _____/_____/_____, hereby authorize
(Name of Minor Child) (Minor Child Date of Birth)

_____, _____
(Name of Adult Bringing Child to Office) (Relationship)

Medical Care:

The undersigned hereby authorizes Steindler Orthopedic Clinic to provide ongoing medical treatment, by physician or physician assistant (including support staff) employed by Steindler Orthopedic Clinic for my minor child when such treatment is deemed necessary by the provider in conjunction with the injury or condition being treated. Such consent may include, but is not limited to medical treatments, tests, x-ray examinations, injections, and/or prescription medications.

This authorization:

- is effective only on ____/____/____.
- is effective from ____/____/____ to ____/____/____.
- is effective until revoked by me in writing.

Phone Number that we can reach Parent/Guardian if Needed.

Signature of Patient or Legal Guardian

Date

Signature of Witness

Date