Name:
DOB:
Chart:
Age:
Date:

The Orthopaedic Group P.C.

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby request and give my permission for the physicians of The Orthopaedic Group, P.C. to provide such medical examination and treatment as they deem best for the physical or mental welfare of _____ in the event that I am unable to accompany the child to the appointment. As parent or legal guardian, I give my full consent to The Orthopaedic Group, P.C. for office billing information, medical examination and treatment or outpatient/inpatient surgical treatment for the above named child. I will notify The Orthopaedic Group, P.C. of any change in the above information or permission. I also give consent for the following people to accompany my child to the appointment:

_____ _____

_____ _____

_____ _____

I understand medical and surgical treatment can include diagnostic laboratory or radiology testing, injections, medical care, or surgery considered necessary in the situation. I set no limitations on treatment of the above named minor other than:

_____

_____

_____

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother, stepfather, referring physician, other physicians involved in the care of my child, and my insurance company(ies).

By signing below, I also authorize The Orthopaedic Group, P.C. to obtain medication history related to the patient listed above for the purpose of continued treatment.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Name of Parent or Legal Guardian

_____ _____

Print Name of Child Date of Birth