SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

CONSENT TO TREAT MINOR WITHOUT PARENT

Name of Child: ____

Child's Date of Birth:____

Name of Parent
Or Legal Guardian: ____

I authorize the person(s) listed below to accompany my child to South Florida Orthopaedics & Sports Medicine to receive medical attention without my appearance. I understand that medical information about my child may be provided to the adult accompanying my child. Further, I consent to the examination and/or treatment of my child by South Florida Orthopaedics & Sports Medicine. I authorize any diagnostic and medical treatment for my minor child listed above, which is deemed advisable and rendered by South Florida Orthopaedics & Sports Medicine.

Name of Adult
Accompanying Child: ____

Relationship to Child:____

This consent and authorization:

☐ is effective only on:_______________________.
(month/day/year)

☐ is effective from: _______________________ to _______________________.
(month/day/year) (month/day/year)

☐ is effective for 180 days from the date of my signature below.

I may revoke this consent in writing at any time.

I understand that I am financially responsible for all services rendered.

Signature of Parent or Legal Guardian: ____________________________

Relationship to Parent: _______________________________________

Date: ____