FLORIDA ORTHOPAEDIC INSTITUTE

CONSENT TO TREATMENT AND CARE OF MINORS

Patient's Name: _____ MR Number: _____
(Please Print) (For Office Use Only)

In my absence, I, _____ hereby give consent to
(Parent/ Legal guardian)

_____ to accompany_____ to Florida
(Person accompanying minor) (Name of minor)

Orthopaedic for his/her follow up visit, including emergency treatment by health care providers affiliated with Florida Orthopaedic Institute.

_____ _____
Signature of Parent/Legal Guardian Date

EMERGENCY PHONE NUMBERS

Mother: _____ Home _____
(Please Print)
Work _____

Father: _____ Home _____
(Please Print)
Work _____

Legal Guardian: _____ Home _____
(Please Print)
Work _____