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 ___________________________

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