



Keeping you active.

**CONSENT TO TREATMENT AND CARE OF MINORS**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Please Print)

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: \_\_\_\_\_  
(Please Print)

Home \_\_\_\_\_

Work \_\_\_\_\_

Legal Guardian: \_\_\_\_\_  
(Please Print)

Home \_\_\_\_\_

Work \_\_\_\_\_