ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

Authorization for Minor's Treatment

Child's full Legal Name:_____

Date of Birth:_____Age:_____ Gender:_____

Doctor:_____

Authorization and Consent of Parent (s) or Legal Guardian(s)

I have legal custody of the aforementioned minor child.

I grant my authorization and consent for Dr_____
to administer treatment for the injury experienced by the minor.

It is understood that this authorization is given in advance of any such medical treatment, but is given to allow the physician to exercise his best judgment in the treatment of the minor in the office setting.

This authorization is effective commencing on _____,
and expiring on _____.

Signed on:_____ by_____
Signature of Parent or Legal Guardian

_____ _____
Name of person accompanying minor Relationship

_____
Signature of person accompanying minor