Treatment Authorization for Minors

I_______________________________ , the parent of or legal guardian of
(List Name of Parent/Guardian)

_______________________________ , a minor, do hereby authorize
(List Name of Patient Who is a Minor)

_______________________________ , as agent for myself in my absence.
(List Name of Authorized Adult)

The agent has my permission to complete required paperwork for the minor and consent to treatments for the minor such as physical examinations, x-rays, medical care, administration of medications and anesthetic, and any other treatments or procedures that the attending medical personnel deem necessary or prudent, including life-sustaining or emergency treatment. It is understood that I am providing this authorization prior to any specific diagnosis or treatment, for the purpose of providing the agent the authority and power to exercise his or her best judgment based upon the advice provided by the medical personnel.

This authorization is in effect for ________________________ , **(List Date of Appointment)** and will expire at the conclusion of treatment on the listed appointment date. This authorization is only valid for an appointment and/or ancillary service rendered at an office of The Jewett Orthopaedic Clinic, P.A.

Parent/Guardian Contact Information:
Home Phone: ___________________
Work Phone: ___________________
Mobile Phone: ___________________
Fax Number: ___________________

_____________________________________ _____________________________
Signature of Parent/Legal Guardian **Signature of Witness**

_____________________________________ _____________________________
Printed Name of Parent/Legal Guardian **Printed Name of Witness**

_____________________________________ _____________________________
Date **Date**