Upper Bucks ORTHOPAEDICS

PERMISSION TO TREAT MINORS

I (We), _____, am (are) the parent(s) or legal guardian(s) of:

_____DOB: _____ grant to _____
(Name and relationship to patient)
the authority to consent to treatment of the above named minor. Should his/her condition

_____(list condition) require treatment, the above named person having physical custody or responsibility for the care of the minor in need may bring this consent to the physician or hospital. This permission may include transportation and/or admission to an appropriate health care facility.

I (We) understand medical or surgical treatment can include diagnostic laboratory or radiology testing, injections, medical care, or surgery considered necessary in the situation We will take financial responsibility as the parent or legal guardian for any treatment rendered. I (We) set no limitations on treatment of the above named minor(s) other than:

_____

_____

I (We) understand that reasonable attempts will be made to contact me (us) in the event of an emergency. This authorization is effective from the date of signature until the following date: _____ (not to exceed 12 months from date of signature).

X_____ X_____

Signature of parent/legal guardian **Signature of parent/legal guardian**

_____ _____ _____ _____

Date **Relationship to Child** **Date** **Relationship to Child**

Telephone #(s) you can be reached at: _____

Additional Information

Primary Care Physician _____ Child's Address _____

City/State/Zip _____Phone _____ City/State/Zip _____Phone _____

Insured Work Place _____ Spouse's Work Place _____

Address _____ Phone _____ Address _____ Phone _____

Health Insurance Company _____

Policy number _____ Policy Group number _____

Name of Policy Holder_____ Policy Holder date of birth: _____

Name and Address of Pharmacy _____Phone _____

Other Contact _____ Address/Phone _____