PERMISSION TO ACCOMPANY A MINOR WITHOUT THE PRESENCE OF A PARENT/LEGAL GUARDIAN

Any child under the age of 18 years old cannot be seen by a doctor without written consent from a parent/legal guardian or without an adult present. If the minor is under 16 years of age, he/she must be accompanied by an adult. If the minor arrives with someone other than a parent/legal guardian, we must have written permission from the parent/legal guardian that this person has been appointed by you to act on your behalf. This accompanying individual must have a photo ID on them at time of the minor's appointment.

Minor's Information

Minor's Name: ____ D. O. B.: __________________________

For those occasions when you may not be with your child, **please list those individual(s) age 18 years or older who will accompany your child and may give us consent for care**:

Name: _____________________________ Telephone # ____________________ Relationship to Minor: _______

Name: _____________________________ Telephone # ____________________ Relationship to Minor: _______

Minor's Health Information

Current prescribed or over-the-counter medications and dosages:

Medication: ____ Dosages: __________________________

Medication: ____ Dosages: __________________________

Medication: ____ Dosages: __________________________

Allergies, illnesses or other comments (if none, state "none"): ____

____

Parent/Legal Guardian Information

Parent/Legal Guardian's Name: ________________________________ D. O. B.: __________________________

Telephone # (you must be available at this telephone # at time of visit): ________________________________

Authorization

I (parent/legal guardian name) ____ request and authorize Boston Orthopaedic & Spine, LLC and its personnel to deliver medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, injections, x-rays, lab work, brace/splint fitting. I have read, understand, and give my consent as stipulated above.

This consent shall be in effect for: ◯ Date: ___________ (only) or ◯ indefinitely, until revoked by written notice.

X___________________________________ ________________________ __________________ _____________

Parent/Legal Guardian's Signature *Print Name* *Relationship to Patient* *Date*

This authorization must be completed in its entirety by the parent/legal guardian or it will not be processed.