AUTHORIZATION TO TREAT A MINOR CHILD IN ABSENCE OF A PARENT OR LEGAL GUARDIAN

Please check one of the following:

☐ The minor child under my legal care is 15-17 years of age, and I give my consent for him/her to attend an **unaccompanied** appointment. In addition, I give my consent for medical care as described below.

☐ The minor child under my legal care is under 15 years of age, and I give my consent to him/her to attend an appointment **accompanied by an adult representative greater than 18 years of age** as designated below. In addition, I give my consent for medical care as described below.

I, _____, the parent or legal guardian of
(Name of Parent or Legal Guardian)

_____, _____/_____/_____, hereby authorize
(Name of Minor Child) (Minor Child Date of Birth)

_____, _____
(Name of Adult Bringing Child to Office) (Relationship)

to accompany my above-named child to office visits with ORA Orthopedics and consent to the examination and/or treatment of my child during the office visits.

Medical Care:
The undersigned hereby authorizes ORA Orthopedics to provide ongoing medical treatment, by physician or physician assistant (including support staff) employed by ORA Orthopedics for my minor child when such treatment is deemed necessary by the provider in conjunction with the injury or condition being treated. Such consent may include, but is not limited to medical treatments, tests, x-ray examinations, injections, and/or prescription medications.

This authorization:

- ☐ is effective only on _____/_____/_____.
- ☐ is effective from _____/_____/_____ to _____/_____/_____.
- ☐ is effective until revoked by me in writing.

_____
Phone Number that we can reach Parent / Guardian if Needed

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Witness Date