Children's Orthopaedic
and Scoliosis Surgery Associates, LLP
Your Kids Are Our Kids™

PERMISSION TO TREAT CHILDREN

I (We), _____, am (are) the parent(s) or legal guardian(s) of: _____ grant to _____ the authority to consent to outpatient or inpatient medical/surgical treatment of any above-named minor(s). Should his/her condition require treatment, the above-named person having physical custody or responsibility for the care of the minor(s) 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, intravenous feedings, injections, blood transfusions, medical care, or surgery considered necessary in the situation. 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), as well as the personal physician listed below, time and conditions permitting. 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**

Additional Information

Primary Care Physician _____ Child's Address _____

City _____ Phone _____ City/State/Zip _____ Phone _____

Insured Work Place _____ Spouse's Work Place _____

Address _____ Phone _____ Address _____ Phone _____

Other Contact _____ Address/Phone _____

Health Insurance Company _____

Policy number _____ Policy Group number _____

Name of Policy Holder_____ Policy Holder date of birth: _____