



### **Authorization and Consent to Treat a Minor**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_

Patient Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**The undersigned does hereby authorize *Professional Orthopedic and Sports Physical Therapy* consent to exam and treat the above mentioned minor by employees of *Professional Orthopedic and Sports Physical Therapy* without a Parent or Guardian present.**

Father or Guardian \_\_\_\_\_  
(signature)

Mother or Guardian \_\_\_\_\_  
(signature)

Witness \_\_\_\_\_  
(signature)

**Important Medical Information (Allergies, Medications, etc.):**

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