Tennessee Valley Bone and Joint

Consent to Treat Minor Authorized Consent

I, The undersigned parent or legal guardian of (Patient Name) _____ (DOB) _____

authorize and consent to treatment of the above named patient, including but not limited to evaluation, treatment, x-ray, anesthetic and /or any other orthopedic care when I am not immediately available in person. Please see list below for Authorized person(s) who may consent to treatment of the above patient (minor).

It is understood that this authorization is given in advance of any such orthopedic medical treatment or diagnosis and provides authority on the part of TVBJ to exercise his or her best judgment to diagnose and treat the patient (minor) named above even when the parent or legal guardian is not present and the person(s) listed below presents with patient.

Person(s) who may consent to treatment (please print)

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Name of Parent or Legal Guardian _____Relationship:_____

Contact Number: _____ Secondary Contact Number: _____

Parent or Guardian Signature: _____Date:_____

This consent will remain in effect until withdrawn by the signee.

Witness Name: _____Signature:_____Phone:_____

Signature of parent or guardian withdrawing consent: _____ Date:_____