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[www.SpineInstituteFL.com](http://www.SpineInstituteFL.com)

## CONSENT TO TREATMENT AND CARE OF MINORS

Patient's Name: \_\_\_\_\_ MR Number: \_\_\_\_\_  
(Please Print) (For Office Use Only)

In my absence, I, \_\_\_\_\_ hereby give consent to  
(Parent/Legal Guarding)

\_\_\_\_\_ to accompany \_\_\_\_\_  
(Person Accompanying Minor) (Name of Minor)

to Spine Institute of Central Florida for his/her follow up visit, including emergency treatment by health care providers affiliated with Spine Institute of Central Florida.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date

### EMERGENCY PHONE NUMBERS

Mother: \_\_\_\_\_ Home: \_\_\_\_\_  
(Please Print)

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Father: \_\_\_\_\_ Home: \_\_\_\_\_  
(Please Print)

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Home: \_\_\_\_\_  
(Please Print)

Work: \_\_\_\_\_



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