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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: _____
(Please Print)

Home: _____

Work: _____

Cell: _____

Legal Guardian: _____
(Please Print)

Home: _____

Work: _____

Cell: _____