PRO SPORT ORTHOPEDICS
EMPOWERING HUMAN PERFORMANCE

☐ **AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR**

In my absence I hereby authorize the following adult(s) to accompany my child to provide consent to medical or surgical treatment for my child _____.

PLEASE COMPLETE:

_____ _____
Print Name Relationship to patient

_____ _____
Print Name Relationship to patient

☐ **CONSENT TO CARE FOR UNACCOMPANIED MINOR**

In my absence I hereby provide consent to Pro Sport Orthopedics authorization to provide needed medical or surgical treatment for my child _____.

Such consent to either section noted above may include, but is not limited to clinic visits, medical treatments, tests, imaging studies: including x-rays, transfusions, injections, immunizations, medications and performing of procedures that may be deemed necessary or advisable.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. It is given to provide Pro Sport Orthopedics and its clinical staff authorization to provide medical care they may deem advisable in the exercise of their best judgement.

This authorization shall remain effective until revocation in writing by the undersigned.

I acknowledge that I am responsible for all changes in connect with the care and treatment rendered to the above minor. If the insurance card and copay (if applicable) is not provided in advance of the treatment, Pro Sport Orthopedics may require an advance deposit.

_____ _____ _____
Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date