SYRACUSE ORTHOPEDIC SPECIALISTS

Consent to Authorize Routine Medical Care of Minor Patient

At times, it may be beneficial for parents or guardians of minor children to authorize routine medical care in advance. This is particularly helpful if a parent or legal guardian cannot be present at the time of treatment. Please complete the following authorization for treatment if you wish to authorize routine medical care for your child. Please note that a parent or legal guardian must be present for any invasive treatment, including aspirations, injections or the use of contrast media during radiologic studies.

AUTHORIZATION

I hereby state that I am the parent of the child named below. I certify that there are *no court orders* pending or final *(i.e. custody or divorce situations)*, that would prohibit me from legally authorizing _____ and its staff to deliver routine health care to the child listed below.

Child's Printed Name: _____ Date of Birth: _____

I authorize the following treatment for my child:

☐ Follow up appt. to check progress of healing ☐ Non-Contrast X-ray or

☐ Orthopedic, Sports and Hand Therapy Services

This authorization expires on (expiration will be no longer than 12 months from date of parent signature unless otherwise specified): _____

CONTACT INFORMATION

If recommended medical care differs from what has been authorized above, I wish to be contacted at the following telephone numbers:

_____

Parent Name & Address Primary Contact # Secondary Contact #

_____

Parent Name & Address Primary Contact # Secondary Contact #

_____

Pharmacy Name & Phone Number if Prescription needs to be called in

_____

Parent or Legal Guardian PRINT / **Parent or Legal Guardian SIGNATURE** / Date