VOS valley orthopaedic specialists

**Main Office:**
2 Trap Falls Rd Ste 404
Shelton, CT 06484
Phone: (203) 734-7900
Fax: (203) 513-3269

**Oxford Office:**
144 Oxford Rd
Oxford, CT 06478
Phone: (203) 734-7900
Fax: (203) 463-8957

**Fairfield Office:**
1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
Fax: (203) 955-1203
www.vosct.com

# Consent for Treatment of Unaccompanied Minor

**Name of Minor: _____ ("Minor")**

**Date of Birth of Minor: _____**

I acknowledge that I am the parent or guardian entitled to the care, custody, and control of "Minor".

I represent that I am unable to accompany "Minor" to his/her appointment with Valley Orthopaedic Specialists on the _____ day of _____, 20___ for examination or treatment.

I hereby request, authorize and direct Valley Orthopaedic Specialists to examine and treat "Minor" in my absence.

I understand that, in certain circumstances, the healthcare providers of VOS may require that a parent or other authorized adult be present with "Minor" to assist in the diagnosis or treatment process. I agree to cooperate by being present at all times possible and when specifically requested by Valley Orthopaedic Specialists.

**Name of Guardian: _____**

**Signature of Guardian: _____**

**Relationship to "Minor": _____**

**Date: _____**