

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: _____