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

Oxford Office:
220 Main St, Ste 1F
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: ______________________________________