

Authorization to Treat a Minor Child In Absence of a Parent or Legal Guardian

Please check one of the following:

___ the minor child under my legal care is 15-17 years of age and I give my consent for him/her to attend an **unaccompanied** appointment. In addition I give consent for medical care as described below.

___ the minor child under my legal care is under 15 years of age and I give my consent for him/her to attend an appointment **accompanied by an adult representative greater than 18 years of age** as designated below. In addition I give consent for medical care as described below.

I, _____, the parent and legal guardian
(Name of Parent or Legal Guardian)

of _____, hereby authorize
(Name of Child)

_____ to accompany my above-named child to
(Name of Person bring child to the office)

office visits with Cape Fear Orthopaedic Clinic and consent to the examination and/or treatment of my child during the office visits.

Medical Care for Current Condition:

The undersigned hereby authorizes Cape Fear Orthopaedic Clinic, as our agent, to provide ongoing medical treatment by any physician, physician assistant or physical therapist (including support staff) licensed through the State of North Carolina and employed by Cape Fear Orthopaedic Clinic, for my minor child, when such treatment is deemed necessary by the physician in conjunction with the current injury/illness being treated by Cape Fear Orthopaedic Clinic.

Emergent Care – If applicable

In addition, I hereby authorize Cape Fear Orthopaedic Clinic, as our agent, to provide emergent care by any licensed physician, physician assistant or physical therapist (including support staff) for the above mentioned minor if I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include but is not limited to medical treatment, tests, x-ray examination, injections or drugs and the performing of whatever procedures 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, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of his or her best judgment.

This authorization: is effective only on _____.
Month/Day/Year

is effective from _____ to _____.
Month/Day/Year Month/Day/Year

is effective until revoked by me in writing.

Signature of Parent or Legal Guardian

Date: _____

Signature of Witness

Date: _____