BETHEL FOOT AND ANKLE

8 School Street---Bethel, CT 06801
Phone: 203-743-7083 Fax: 203-744-2811

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I,_____ parent or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of local anesthesia determined by the physician to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available by telephone to give consent.

This authorization is effective from_____ to_____.

_____ _____

Signature of Parent of Legal Guardian **Date**

_____ _____

Witness Signature Witness Name(please print)

This consent form should be either brought in with the child at time of treatment or emailed to the physician's office. Thank you

This additional information will assist in treatment if it can be furnished with the consent but is not required:

Family Address:_____

Telephone: Father:_____ Cell:_____ Work:_____

Mother_____ Cell:_____ Work:_____

Child's Physician:_____ Phone:_____