Winchester Orthopaedic Associates, Ltd.

CONSENT TO TREATMENT OF A MINOR
IN ABSENCE OF PARENT/GUARDIAN

I, _____, the parent/legal guardian of _____,
(Name of parent/guardian) (Name of child)

hereby authorize _____ to accompany my above-named child to
(Name of adult accompanying child to office)

office visits at Winchester Orthopaedic Associates, Ltd., and to consent to the examination and/or treatment of my child during the office visits.

This authorization is effective (choose one):

- ☐ only on _____.
  DATE
- ☐ from _____ to _____.
  DATE DATE
- ☐ until revoked by me in writing.

I reserve the right to revoke this authorization at any time, by notifying Winchester Orthopaedic Associates, Ltd. in writing.

I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment of the adult listed above.

_____ _____

Signature of Parent/Guardian Date Signature of Office Staff Witness Date

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TELEPHONE/VERBAL CONSENT TO TREATMENT OF A MINOR

I, _____, an employee of Winchester Orthopaedic Associates, Ltd., have
(EMPLOYEE'S NAME)

obtained verbal permission from _____, _____, for
(PARENT/GUARDIAN NAME) (RELATIONSHIP)

examination and treatment of _____, a minor, prior to any medical
(PATIENT'S NAME)

services being performed.

Date of Verbal Consent: _____