AUTHORIZATION AND CONSENT TO TREAT A MINOR ABSENT CUSTODIAL PRESENCE

Date: _____

Minor's Patient Number:_____

Minor's Name:_____

Minor's Date of Birth:_____

I, the undersigned parent or legal guardian of the above-mentioned minor ("Minor"), affirm that I have legal custody of the Minor and do hereby consent to Provider's examination and rehabilitation therapy treatment of the Minor without a parent or legal guardian present; provided, however, in the event the Minor is under the age of 12, I agree to be present while the Minor is being treated. I further affirm all of the Minor's allergies, past medical history and known health issues have been disclosed in writing on Provider's patient intake forms.

Parent's Signature:_____Date:_____

Parent's Name:_____

Relationship to Minor:_____

Legal Guardian Signature:_____Date:_____

Legal Guardian Name:_____