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

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

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: __________________________