

# Orthopedic Specialists

## Parental Authorization for Medical Services

Please mark (✓) appropriate option(s):

- I hereby give authorization for my child to be seen by the physician without a parent or legal guardian present.
  
- I authorize the physician to do a medical examination and perform appropriate non-invasive treatment, including x-rays, and report the findings and treatment plan to myself.
  
- I hereby state that my child's immunizations are up to date.

\_\_\_\_\_  
Minor's Name (print)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name (Please Print)