CENTER FOR FOOT AND
ANKLE RESTORATION

PARENTAL AUTHORIZATION FOR MEDICAL SERVICES

Please Mark the 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: ______________________________ Date: ____________________

Parent or Legal Guardian's Name: ____________________________________

Parent or Legal Guardian's Signature: ____________________________________