STEINDLER
ORTHOPEDIC CLINIC

2301 Steindler Way, Suite B, North Liberty, IA 52317
(319) 338-3606 • (800) 373-6417 • Fax: (319) 338-0522
Steindler.com

AUTHORIZATION TO TREAT A MINOR CHILD IN ABSENCE OF A PARENT OR LEGAL GUARDIAN

_____ _____
Name of Parent or Legal Guardian (Print) Signature of Parent or Legal Guardian

_____ _____
Date Phone Number to Reach Parent/Guardian if Needed

_____ _____
Name of Minor Child Minor Child Date of Birth

_____ _____
Name of Adult Bringing Child to Office (If Applicable) Relationship

Please check one of the following:

☐ The minor child under my legal care is 15-17 years of age, and I give my consent for him/her to attend an **unaccompanied** appointment. In addition, I give my consent for medical care as described below.

☐ The minor child under my legal care is under 15 years of age, and I give my consent to him/her to attend an appointment **accompanied by an adult representative greater than 18 years of age** as designated below. In addition, I give my consent for medical care as described below.

Medical Care:

The undersigned hereby authorizes Steindler Orthopedic Clinic to provide ongoing medical treatment, by physician or physician assistant (including support staff) employed by Steindler Orthopedic Clinic for my minor child when such treatment is deemed necessary by the provider in conjunction with the injury or condition being treated. Such consent may include, but is not limited to medical treatments, tests, x-ray examinations, injections, and/or prescription medications.

This authorization:

☐ is effective only on _____. (Date)

☐ is effective from _____ to _____. (Dates)

☐ is effective until revoked by me in writing.

_____ _____
Signature of Witness Date

_____
Patient Account Number (For Office Use)