Proliance SURGEONS
Everett Bone & Joint

AUTHORIZATION AND CONSENT FOR MINOR'S MEDICAL TREATMENT

CHILD'S INFORMATION

Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Allergies to Medications: _____

Allergies (Other): _____

Note any other significant medical information: _____

PARENT(S)/LEGAL GUARDIAN(S)INFORMATION

PARENT/GUARDIAN #1:

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Additional Contact Information: _____

PARENT/GUARDIAN #2:

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Additional Contact Information: _____

DESIGNATED ALTERNATE(S) IN THE EVENT PARENT(S)/LEGAL GUARDIAN(S) ARE NOT AVAILABLE

ALTERNATE #1:

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip _____

Home phone: _____ Alt. phone: _____

Additional Contact Information: _____

ALTERNATE #2:

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip _____

Home phone: _____ Alt. phone: _____

Additional Contact Information: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)