GUARDIAN PERMISSION

I, _____ give permission to OAA Orthopaedic Specialists to allow the

medical treatment consisting of _____for:

_____
(Print full name of child)

In my absence for the diagnosis of: _____.

Parent/Guardian will be available by telephone during visit for provider to contact if necessary at the following numbers:

Phone 1: _____

Phone 2: _____

I understand that OAA Orthopaedic Specialists reserves the right to rescind this permission should the treating physician and/or therapist believe that it is necessary to have the parent or legal guardian present at the time of treatment.

_____ _____
(Signature of Parent or Legal Guardian) (Date)

_____ _____
(Signature of Witness) (Date)