



all american orthopedic  
& SPORTS MEDICINE INSTITUTE

## CONSENT TO TREAT A MINOR

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Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

Guardians Phone \_\_\_\_\_

I, \_\_\_\_\_, parent/ legal guardian of \_\_\_\_\_,  
do hereby consent to any medical care of and administration of medications determined by a physician to be  
necessary for the welfare of my child while said child is under the care of the above named physician and/  
or their staff.

I do hereby indemnify and hold harmless the physicians and other healthcare workers who act in reliance with  
this authorization.

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent/ Guardian

Date

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize the physician and/or physician's representative to release healthcare information of  
the patient named above to:

Names of trainers/coaches/other physicians/ other \_\_\_\_\_

Signature of Guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_