791 West Genesee Street
Skaneateles, New York 13152
Tel: 315-685-7544 Fax: 315-685-7549
victorysportsmedicine.com

Date: _____

FOR INTERNAL USE ONLY
ACCT# _____
CSR _____

CONSENT FOR TREATMENT OF A MINOR BY PARENT OR LEGAL GUARDIAN

Patient Information	
Name of Minor Patient (Last, First, Middle):	**Date of Birth:**

Permission to Treat:

1. I am the mother or father or legal guardian of the Minor Patient.

2. I hereby certify that I have the right to consent to Minor Patient's medical treatment and that I am not prohibited from doing so by any agreement or court order.

3. I hereby give my authorization and consent to examinations, x-rays, MRIs, physical therapy services and other medical services provided to the Minor Patient on the advice of any Victory Orthopedics provider with respect to _____.
   Side of body & body part

Consenting Party Information:				
Name of Consenting Party (Last, First, Middle):				
Relationship with Minor Patient (Parent or Legal Guardian):				
Consenting Party Street Address:	**P.O. Box:**	**City:**	**State:**	**Zip Code:**
Minor Patient's Street Address (if different from above):	**P.O. Box:**	**City:**	**State:**	**Zip Code:**
Consenting Party Phone Numbers: **Home Phone:**	**Cell Phone:**		**Work Phone:**	

_____ _____

Signature of Consenting Party Date