ST CLOUD ORTHOPEDICS

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PERMISSION TO AUTHORIZE MEDICAL CARE FOR MY CHILD AT ST. CLOUD ORTHOPEDICS/ORTHOPEDIC SPORTS CENTER

Account #:_____

I give permission for the following individuals to authorize medical care for my,

minor child _____ for _____.
Patient Name Condition

1)_____
Relationship

2)_____
Relationship

3)_____
Relationship

This permission is limited as follows:

_____ not limited

_____ limited for the period _____ to _____ (dates).

Authorized by: _____
Mother/Father/Guardian (circle relationship to patient)

Date:_____

Telephone number of Parent or Guardian:_____