**1901 CONNECTICUT AVE. S**

 **SARTELL, MN 56377**

 **MAIN 320-259-4100**

 **FAX 320-259-8044**

[**WWW.STCLOUDORTHOPEDICS.COM**](http://WWW.STCLOUDORTHOPEDICS.COM)

**WRITTEN CONSENT FOR ST. CLOUD ORTHOPEDICS/**

**ORTHOPEDIC SPORTS CENTER**

**TO TREAT A MINOR CHILD**

Account #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give written consent for St. Cloud

 Parent/Legal Guardian

Orthopedics/Orthopedics Sports Center to provide treatment to my minor child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Name Condition

I understand if there is a change in my child’s condition/treatment, another consent form will need to be signed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Legal Guardian (circle relationship to patient)

mak/minor consent form with guardian present 2