AUTHORIZATION TO TREAT A MINOR CHILD IN ABSENSE OF A PARENT OF LEGAL GUARDIAN

I, being the parent or legal guardian of _____ do hereby the request and authorize the physician(s) and staff of Cape Fear Orthopaedic Clinic, P.A. to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

I understand that Cape Fear Orthopaedic Clinic, P.A. requires that all minor children age 15 and under, be accompanied by an authorized adult.

Below is a list of individuals who have permission to bring my child in for treatment:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Signature of Parent or Legal Guardian: _____

Date: _____ **Time:** _____ **am/pm**

Signature of Witness: _____

Date: _____ **Time:** _____ **am/pm**