PEDIATRIC ORTHOPEDIC ASSOCIATES OF SAN ANTONIO

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Consent for Medical Treatment

The undersigned (individually, jointly, and severally), in presenting my child / children in my absence for diagnosis and treatment for routine or emergency medical care, as the parent/guardian of:

____,

Patient's Full Name / Date of Birth

do voluntarily consent to the rendering of such care and medical and surgical treatment, including physical examination and diagnostic procedures by POASA, as may in their professional judgment be necessary in the best interest of my child.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents. I hereby give my consent to:

____

Name of Person or Agency and Telephone Number

who will be caring for the child from __________________to________________ to arrange for routine or emergency medical or dental care and treatment necessary to preserve the health of the child.

I acknowledge that I am responsible for all charges in connection with care and treatment during this period. The authority to consent to treatment herein is subject to the following conditions or exclusions:

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Parent / Guardian Signature   Date

NOTE: Signature of delegated adult must be compared by driver's license or identification card at time of

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service.

______________________________ Delegated Adult Signature

______________________________ Date