FAMILY FOOT & ANKLE PHYSICIANS, PLLC

J. SCOTT STANCIL, DPM
AMY PITZER, DPM
RICK CHEN, DPM
BRIAN JONES, DPM

1432 East Fire Tower Road
Greenville, NC 27858
(252) 439-1150

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____,
DOB _____/_____/_____do hereby consent to any medical care and the administration of anesthesia determined by Family Foot & Ankle Physicians, PLLC to be necessary for the welfare of my child while said child is under the care of _____

Address_____

_____

and I am not reasonably available by telephone to give consent. This authorization is effective from the _____ day _____, 20___ to____ day _____, 20__.

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Witness Signature **Witness Name (please print)**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address:_____

Father's Telephone:_____Mother's Telephone:_____

Last Tetanus:_____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician:_____Phone: _____

Insurance:_____Policy#:_____

Preferred Hospital:_____