METRO SPORTSMED®
Physical & Occupational Therapy
POWERED BY MOTIONPT GROUP

TREATMENT CONSENT FORM FOR MINORS

(Form to be completed by Parent or Legal Guardian for any patients under the age of 18)

METRO SPORTSMED® is required to protect the rights of our patients and ensure the safety of minors. Any new patient under the age of 18 must be evaluated in the presence of their Parent/Legal Guardian. It is important that the Parent/Legal Guardian be aware of the minor's condition(s) and informs the treating clinician.

Patient Name: _____

Patient Age: _____

Parent/Legal Guardian: _____

Relationship to Patient: _____

I, "Parent/Legal Guardian" do hereby authorize the staff of METRO SPORTSMED® (licensed Physical and Occupational Therapists) to provide "Patient" with effective rehabilitative treatment pursuant to the prescription from his/her physician as deemed advisable by METRO SPORTSMED® staff for his/her care and well-being.

Please select one of the following (A OR B):

❑ A. I, hereby grant METRO SPORTSMED® permission to treat "Patient" whether or not "Patient" is accompanied to treatment session.

OR

❑ B. I, "Parent/Legal Guardian" hereby authorize the rendering of Physical and/or Occupational Therapy treatment exclusively in my presence or in the presence of the below designated representative(s). In the absence of "Parent/Legal Guardian" or the representative(s) listed below, treatment shall NOT be rendered.

Name of Representative(s): _____

Relationship to Patient: _____

I confirm that I have read and fully understand the above.

Parent /Legal Guardian: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Emergency Contact Information

Parent/Legal Guardian: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Alternate Contact: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____