Authorization for Physical Therapy Treatment of Minors

I, ____, parent or legal guardian of:

____ ________________________

(Child's Full Name) (Child's Date of Birth)

do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my children to physical therapy appointments.

Name and Relationship:

____

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Please list anyone other than the child's legal guardian who may be accompanying the child to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc…

_________I understand that only my child's legal guardian and those listed will have the authority to authorize treatment.

_________I authorize my child to attend physical therapy appointments independently.

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Hobson Institute of any changes in my child's health status, or the above information. I understand that this consent is valid for one year.

____ ____________________

Signature Date