Authorization and Consent to Treat Minor

Date:___/_____/_________ .

Patient Name:_________________________.

Patient Birthdate:________/_________/_________.

The undersigned does herby authorize Virginian Physical Therapy and Staffing LLC consent to exam and treat the above mentioned minor by employees of Virginian Physical Therapy and Staffing LLC without a parent or guardian present.

Father or Guardian:____

(Signature)

Mother or Guardian:____

(Signature)

Witness:____

(Signature)

Important Medical Information (Allergies, Medications, etc):

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