

CONSENT TO TREAT MINOR CHILDREN

DATE: / /

Please **print** all information

I, _____, parent or legal guardian of _____,

born ____/____/____, do hereby consent to any physical therapy care, including, but not limited to the administration of therapeutic modalities (thermal, ultrasonic, electrical, mechanical), therapeutic exercise and manual therapeutic techniques determined by a physical therapist to be necessary for the welfare and physical recovery of my child while said child is under the care of New York Physical Therapy Management, P.C. during scheduled appointments at the place of practice specified above.

This authorization is effective from ____/____/____ to ____/____/____; **or** INDEFINITE; ____ YES ____ NO

Signature of Parent or Legal Guardian: _____ Name _____

Witness Signature

Witness Name (please print)

Family address _____

Telephone: Father _____ home _____ work _____
 Mother _____ home _____ work _____

Child's Birthdate _____ Last Tetanus _____

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Allergies to drugs or foods _____

Special Medications, Blood Type or Pertinent Information

Child's Physician _____ Phone _____

Preferred Hospital _____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for EMERGENCY treatment.