Leesburg High School
Permission to Treat a Minor without a Parent/Legal Guardian Present

Florida Sports Injury & Orthopedic Institute must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. A new "Permission to Treat Minor without a Parent/Legal Guardian Present" form is required for each visit that a minor is seen without his/her parent/guardian. A copy of the parent/guardian's driver's license and the patient's valid insurance card is **REQUIRED** for each visit. Please bring co-pay (if applicable) to the visit.

Minor
Full Legal Name: _____
Home Address: _____
Date of Birth: _____ Gender: _____ SSN: _____

Parent/Legal Guardian
Full Legal Name: _____
Home Address: _____
Date of Birth: _____ Gender: _____ SSN: _____

Information for Medical Treatment
Name of Responsible Party: _____ Medical Insurer/Health Plan: _____
Policy #: _____ Group #: _____
Do you have School Insurance for the current school year (circle one)? YES NO
Allergies to Medication: _____
Allergies (Other): _____
Date of Injury: _____
Please note ALL conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information:
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)
I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to arrange for and authorize routine and emergency treatment at Florida Sports Injury on _____ (date). If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-rays, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

In case of emergency, I can be reached at:
Cell Phone Number: _____ Home Phone Number: _____
Work Phone Number: _____

Signed this _____ day of _____, 20____.

Parent/Legal Guardian Signature: _____ Printed Name: _____

Witness Signature: _____ Printed Name: _____