ASP Orthopedics AND Sports Medicine

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A DIVISION OF THE ASSOCIATION OF SPECIALTY PHYSICIANS INC.

CONSENT FOR MEDICAL EVALUATION AND TREATMENT BY PHYSICIANS OF ASSOCIATION OF SPECIALTY PHYSICIANS

Note to all parents/guardian: This form authorizes the physicians of Association of Specialty Physicians to provide medical evaluation and treatment of your child in your absence. This form will be kept on file to facilitate the evaluation and treatment of your child. Please complete and return this form to Association of Specialty Physicians via fax or have your child bring it to the office at his/her next scheduled appointment.

We/I hereby give consent to the office of Association of Specialty Physicians to evaluate, perform diagnostic procedures and provide medical treatment to our/my child,_____, in case we are/I am not available.

We/I give permission for:
(Name)_____
Relationship)_____to be present at my/our child's appointment.

We/I acknowledge that we are/I am responsible for all reasonable charges incurred in connection with the care and treatment rendered during this period.

_____ _____
(Date) (Signature of parent/guardian)

_____ _____
(Date) (Signature of parent/guardian)

Child's Health History

Allergies:

_____
_____

Medications with dosage:

_____
_____

Pediatrician/Family Doctor and telephone number:

_____
_____

Current or Chronic Illness:

_____
_____

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