ALIGN
FOOT AND ANKLE

Dr. Zachery Barnett, FABPM ACFAS

CONSENT TO TREAT:
MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care determined by **Dr. Zachery P. Barnett** to be necessary for the welfare of my child while said child is under the care of **Align Foot and Ankle** and I am not reasonably able to give consent.

This authorization is effective from _____ to _____.

_____
Parent or Legal Guardian Name (please print)

_____
Signature of Parent or Legal Guardian

_____
Witness Name (printed) Witness Signature

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

Patient/Guardian address _____

_____

Phone _____ Cell _____

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods:

_____

_____

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