Chattanooga Foot & Ankle Clinic

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

Patient Name _____ DOB _____

I give permission to the physicians, providers, and nurses of Pediatric Associates of Franklin to treat my child in my absence. I authorize any medical treatment necessary in my absence and in the event of an emergency for the well-being of the minor mentioned above.

It is understood that this consent is given before any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   I give permission for _____ (child's name), who is 16 or older, to be treated unaccompanied. In the event the provider needs to speak with me, I can be reached at (telephone number) _____.

2. Medical concerns: _____
3. Known allergies: _____
4. Medications _____

Name of Parent or Legal Guardian*: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork. Please attach a copy of legal guardian drivers license or other valid legal document, such as a passport, military ID, or alien/resident card

This Consent is effective until withdrawn in writing by the child's parent or guardian or until the child turns 18.