CHIPPEWA VALLEY ORTHOPEDICS AND SPORTS MEDICINE

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient Name: ______________________________________ **Date of Birth:** _____________________

I hereby authorize _______________________________________ to bring the above-named individual to a
(Name/Relationship to Patient)

Chippewa Valley Orthopedics provider for care.

This authorization is in effect on (todays date):____ /____ /_____

This authorization ends (Check one): ☐ on ____ /____ /_____
OR
☐ when revoked by me/us

CONSENT

To comply with Wisconsin law, Chippewa Valley Orthopedics requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) accompany any minor children (17 years old or younger) to their medical (to include possible x-ray/ MRI/CT scan) appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical treatment appointment, the parent or legal guardian must sign this consent form for treatment of minors.

By signing below, I, the parent/guardian, consent to care and treatment for my child related to his/her medical treatment appointment at Chippewa Valley Orthopedics.

Parent/Guardian Signature: _______________________________________ **Date:** ___________________

Parent/Guardian Name and Relationship (Print): ____

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone number: (_____) _____ - ________