

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____,
(parent/guardian giving consent)

give _____ at Charlotte B Alexander, M.D.

permission to treat _____
(patient's name)

for _____ on _____.
(injury or illness) (date being treated)

I consent to treatment that is reasonable and medically necessary including any
x-rays, lab work and casting.

Signature _____ Date _____

Relationship to patient _____