Advanced
Prosthetic Services

Consent for Treatment of Minor Child

Patient's Name _____
Date of Birth _____

I, _____ hereby authorize and request the designated clinicians and/or designated assistants of Advanced Prosthetic Services to provide the needed orthotic and/or prosthetic item(s) for:
_____ (minor's name).

If the devices are being fit in a classroom or therapy setting, I need not be present for the devices to be provided, and my child's teacher or therapist is hereby authorized to sign for the devices in my absence.

_____ _____
Parent or Guardian Signature Date