

**PARENT/GUARDIAN CONSENT
FOR MEDICAL TREATMENT**

Patient's Name _____

I give my permission to the staff of Pediatric Therapy Services, Inc. to administer medical aid to my son / daughter, _____, or seek and have aid given from a physician or hospital if the situation requires same.

Notary Seal

This instrument was acknowledged

before me this _____
by _____
who has produced _____
as identification and who did
not take an oath

Signature of Parent or Guardian Date

Address of Parent or Guardian

Telephone Number

In case of emergency & parent /guardian cannot be reached, please contact:

Name

Address

Notary Signature

Telephone Number

Physician's Name _____

Physician's Telephone _____

Family / Medical / Hospital Insurance Carrier _____

Policy # / Group # _____

This consent is valid from date of signature until discharged from Pediatric Therapy Services Inc.