SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

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# CONSENT TO TREATMENT AND CARE OF MINORS

Patient's Name: ________________________ MR Number: ______________
(Please Print) (For Office Use Only)

In my absence, I, ______________________________ hereby give consent to
(Parent/Legal Guarding)

______________________________ to accompany ______________________________
(Person Accompanying Minor) (Name of Minor)

to Spine Institute of Central Florida for his/her follow up visit, including emergency treatment by health care providers affiliated with Spine Institute of Central Florida.

______________________________ ______________________________
Signature of Parent/Legal Guardian Date

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EMERGENCY PHONE NUMBERS

Mother: ______________________________
(Please Print)
Home: ______________________________
Work: ______________________________
Cell: ______________________________

Father: ______________________________
(Please Print)
Home: ______________________________
Work: ______________________________
Cell: ______________________________

Legal Guardian: ______________________________
(Please Print)
Home: ______________________________
Work: ______________________________
Cell: ______________________________