Active Foot and Ankle
Whitney R. Holsopple D.P.M.
828 Central Avenue, Greenville
937-459-5432

Parental Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Home Address Home Phone Number

_____
City, State, Zip Code

_____ _____
Parental Contact Phone Number

Caregiver's Information

_____ _____
Caregiver's Name Phone Number

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures, (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named child, which may be required during my absence. Please attempt to contact me at the following telephone number: _____

This consent serves as permission for treatment by Dr. Whitney R. Holsopple. Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until _____
Month, Day, Year

Signatures

_____ _____
Parent/Guardian (circle one) Date

_____ _____
Parent/Guardian (circle one) Date