72 Main Street Little Falls NJ 07424

T: (973) 857-1616 F: (973) 500-6806

Authorization and Consent to Treat a Minor

Date:______ /_______/ _______

Patient Name: ____

Patient Birthdate: _____ /____/____

The undersigned does hereby authorize *Total Recovery Physical Therapy* consent to exam and treat the above mentioned minor by employees of *Total Recovery Physical Therapy* without a Parent or Guardian present.

Parent or Guardian _______________________________________

(Name)

Parent or Guardian _______________________________________

(signature)

Witness ____

(signature)

Important Medical Information (Allergies, Medications, etc.):

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