

PARENTAL CONSENT

Date: _____

Patient Name: _____
(Please Print)

Parent/Legal Guardian Name: _____
(Please Print)

**I, (Legal Guardian) _____, give my permission for
Dr. _____ with Metrocrest Orthopaedics and Sports Medicine to
evaluate/treat (child) _____ in my absence.**

**If there are any immediate questions and/or concerns, I may be contacted at
(telephone #) _____.**

Signature of Parent/Legal Guardian

Date