

Jain Hand Surgery Center

Consent for Treatment of a Minor

I hereby authorize the treatment, administration of anesthesia, and surgical treatment(s) for my minor child

in the event of a medical situation occurring during my absence when the physician(s) or staff are unable to contact me. This authorization extends to both physician(s) and nursing personnel involved in the treatment of my child or child for which I am the legal guardian. I release the physician and any individual designated by the physician, as well as the health care facility in which such care is provided, from liability while performing indicated procedures for my minor child.

Signature of parent or legal guardian

Date

Witness

Date

Notary

Date

This authorization may be considered invalid if it has not been notarized.

Expiration date of authorization