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CONSENT FOR TREATMENT OF A MINOR

Patient Name: ____________________ Date of Birth: _______________ Today's Date: __________

I, the undersigned parent/guardian of ___________________________, a minor, do hereby authorize and direct Christopher R. Rothock, MD and the staff of St. Louis Sports Health to provide orthopedic-related healthcare services. This consent shall remain in effect until ____________ or until revoked in writing.

Name	Relationship	Witness	Date

Telephone Consent

1. Consent by telephone may be obtained when prompt treatment is needed or desirable if an adult patient is unable to give consent, or the patient is a minor.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consents should be followed up with a signature or fax. The fax should be attached.

Name	Relationship	Telephone	Date
Witness	Date	Witness	Date