CONSENT OF PARENTS OR GUARDIANS FOR MEDICAL TREATMENT OF MINOR CHILD

I(We) hereby give my(our) cor	nsent to
	(Name of Person(s)/Agency)
Who will be caring for my(our)	(Name of Child)
	,
Arizona Orthopaedic Associat the physicians and/or provide during this time frame. I(We) my(our) designee. I(We) cons my(our) behalf any first aid or	to to to present my(our) child to es at Gateway for examination and treatment by sof Arizona Orthopaedic Associates at Gateway consent that the plan of care will be discussed with sent that my(our) designee may authorize on medical care that my(our) designee deems eatment of any illness or injury of my(our) minor stody.
	at I(we) am(are) responsible for all charges incurred large rendered during this time period.
Signature of parent or legal guardia	n Date
Signature of parent or legal guardia	n Date
STATE OF ARIZONA	ACKNOWLEDGMENT
County of	
On this date,	known to me or satisfactorily proven to be the
person whose name is subscribed t same.	this instrument and acknowledged that he/she executed the
Subscribed and sworn to before me	this,
Notary Public	Notary Expiration Date