

# Central Texas Pediatric Orthopedics and Scoliosis Surgery

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## Consent for Treatment in Absence of Legal Guardian

Date: \_\_\_\_\_

I, \_\_\_\_\_, as the legal guardian of patient \_\_\_\_\_,  
(Guardian's Name) (Pt. name)

date of birth \_\_\_\_\_, do hereby give permission to \_\_\_\_\_  
(Responsible Party)

to make any legal decision during my absence for date of service \_\_\_\_\_.

Dr. \_\_\_\_\_ may proceed with necessary treatment.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Signature of Responsible Party

Verbal consent given by: \_\_\_\_\_

Witness: \_\_\_\_\_