BRONSON *9004501*	Affix Patient Label
	Patient Name: Date of Birth:

BRONSON HEALTHCARE GROUP
Parental Authorization for Minor

We or I _____, the Parent(s) or Guardian(s) or Power of Attorney
of_____give Bronson and its Employees the right to treat my son or daughter, or legal ward at their scheduled rehab, office visit or diagnostic testing. Treatment includes, evaluation and consent to any procedure completed during an office or rehab visit. This includes and is not limited to x-rays, breathing treatment and laboratory tests.

This treatment is to include Medications? ☐ Yes ☐ No

This treatment is to include Immunizations? ☐ Yes ☐ No

STATEMENT BY PARENT OR GUARDIAN AUTHORIZING AN ADULT OTHER THAN THEMSELVES TO OBTAIN TREATMENT FOR A MINOR CHILD

I hearby Authorize the ADULTS NAMED BELOW* (must be 18 years of age or older) to accompany my minor to his/her scheduled appointment and schedule ongoing appointments.

_____
Patient Name

1. _____
Authorized person Phone number Relationship to patient

2. _____
Authorized person Phone number Relationship to patient

3. _____
Authorized person Phone number Relationship to patient

BRONSON SHOULD BE MADE AWARE OF ANY SPECIAL CUSTODIAL RELATIONSHIPS. IF APPLICABLE, PLEASE EXPLAIN IN THE SPACE BELOW. DOCUMENTATION MAY BE REQUIRED.
(Example: parents are divorced but only one parent has guardianship, etc.)

_____
_____
_____

IF YOUR CHILD IS UNDER 16 YEARS OF AGE:
Parent, Guardian, Power of Attorney or Authorized Adult should remain in the Therapy Department while the child is in Therapy.

IF YOUR CHILD IS OVER 16 YEARS OF AGE:
Do you Authorize the child listed above to Attend Bronson Appointments by himself/herself?(circle one)
YES NO

I understand this authorization will expire in one year from date signed.

Legal Guardian/Parent Signature:_____Date:_____Time:_____
Emergency Contact Number:_____