

PERMISSION TO TREAT A MINOR

I give my permission for my minor child, _____,
(Child's Name)

_____, _____, to receive
(Child's SSN) (Child's Date of Birth)

Physical therapy services or/and Occupational therapy services by
Health Sphere Wellness Center. Additionally, I sign that I am the full
legal guardian of this minor child and am responsible for all decisions
made on behalf of this child pertaining to his/her physical health.

Parent or Legal Guardian Signature

Date

Printed Parent or Legal Guardian's Name

Witness Signature

Date