



Advanced Prosthetic Services

Consent for Treatment of Minor Child

Patient's Name _____
Date of Birth _____

I, _____ hereby authorize and request the designated
clinicians and/or designated assistants of Advanced Prosthetic Services to provide the
needed orthotic and/or prosthetic item(s) for:
_____ (minor's name).

If the devices are being fit in a classroom or therapy setting, I need not be present for
the devices to be provided, and my child's teacher or therapist is hereby authorized to
sign for the devices in my absence.

Parent or Guardian Signature

Date