Foxhall Podiatry Associates, PC

Consent for Treatment of a Minor Child

I, being the parent or guardian of _____, do hereby request and authorize the physicians and staff of Foxhall Podiatry Associates, PC to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Witness Date

Patient DOB:_____

*This form should be witnessed by a member of the Foxhall Podiatry staff. If you are unable to accompany your child to his/her initial appointment, your signature must be notarized.