



HARRISBURG FOOT AND ANKLE CENTER



ALLAN B. GROSSMAN, DPM, FACFAS, FAPWCA
AMBER L. TREASTER, DPM, AACFAS, AAPWCA
DANIEL J. YARMEL, DPM, AACFAS, AAPWCA

GUARDIAN CONSENT FOR TREATMENT OF A MINOR

I give consent for _____ to receive podiatric care in my absence by Allan B. Grossman, D.P.M., Amber L. Treaster, D.P.M. and/or Daniel J. Yarmel, D.P.M. at Harrisburg Foot and Ankle Center, Inc.

Select either A or B:

A. My child will be accompanied to his/her visit(s)

By

Name of chaperone

Name of chaperone

Name of chaperone

Relationship to child

Relationship to child

Relationship to child

B. My child is 16 years of age or older, and will be coming to his/her visits without a chaperone. My child has my permission to sign any medical consent and/or accept medical advice, medications, and other information on my behalf.

Signature of parent/legal guardian

Patient date of birth

Witness

Date