DREVNA
PHYSICAL THERAPY ASSOCIATES
160 North Pointe Blvd., Suite 113
Lancaster, PA 17601
717-569-4184

AUTHORIZATION FOR MEDICAL TREATMENT

I (We) the undersigned parent(s) or person(s) having legal custody or being the legal guardian of _____(minor) born on _____, do hereby authorize Drevna Physical Therapy Associates to provide medical care in the form of physical and/or occupational therapy to the above named minor.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority to the treating therapist in the exercise of his or her best judgement in providing medical care to the above named minor.

In giving this consent, I understand that attempts will be made to contact me in the event of any unforeseen situation arising during his physical and/or occupational therapy treatment which may require immediate medical care. In such situations, I authorize a health care provider to exercise his/her professional judgement and choose the necessary treatment from available alternatives and to render such care and perform such treatment as he/she determines to be necessary for the health and safety of my minor child.

This authorization is effective commencing on _____20_____ and expiring on _____20_____.

Date of signature(s)_____

_____ _____
Signature of parent #l Printed Name of parent #1

_____
Contact Telephone

_____ _____
Signature of parent #2 Printed Name of parent #2

_____
Contact Telephone