DREVNA HUDSON
PHYSICAL THERAPY

700 Eden Rd
Lancaster, PA 17601
Phone: (717) 569-4184
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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-Hudson Physical Therapy 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 judgment 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 judgment 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