



BETHEL FOOT AND ANKLE

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CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____ parent or legal guardian of _____,
born _____, do hereby consent to any medical care and the administration
of local anesthesia determined by the physician to be necessary for the welfare of my child while
said child is under the care of _____ and I am not
reasonably available by telephone to give consent.

This authorization is effective from _____ to _____.

Signature of Parent of Legal Guardian	Date

Witness Signature

Witness Name(please print)

**This consent form should be either brought in with the child at time of treatment or
emailed to the physician's office. Thank you**

This additional information will assist in treatment if it can be furnished with the consent but is not
required:

Family Address: _____

Telephone: Father: _____ Cell: _____ Work: _____

Mother _____ Cell: _____ Work: _____

Child's Physician: _____ Phone: _____