SIERRA
Orthopedic Laboratory, Inc.

Consent for Treatment
Minor Child

Minor's Name: _____ Date of Birth: _____
(Patient Name)

I, _____ hereby authorize and request the designated
(parent or legal guardian name)
clinicians and/or designated assistants of Sierra Orthopedic Laboratory to provide the needed orthotic and/or prosthetic item for:

_____ (Minor's Name).
(Patient Name)

x_____ _____
Parent or Guardian Signature Date

Address:

_____

_____

_____

4847 Old Redwood Hwy, Santa Rosa CA 95403
(707) 528-9808 ◆ (800) 315-9808 ◆ Fax: (707) 528-9818
www.sierraortho.com