



The Foot Clinic, LLC

Ali Davis, D.P.M. F.A.C.F.A.S.

Board Certified in Foot and Ankle Surgery and Wound Care

CONSENT TO TREAT MINOR CHILDREN (PLEASE PRINT)

If I, _____, parent/legal guardian of _____,
born on _____, am not available by telephone, I hereby consent to any medical care and
procedures determined by Dr. Ali Davis to be necessary for the welfare of my child while under the care
of the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

***This consent form should be taken with the child to the hospital
or physician's office when the child is taken for treatment.***

This additional information will assist in treatment if known but is not required.

Contact Information: Father _____ Phone: _____

Mother _____ Phone: _____

Child's Allergies: _____

Child's Primary Physician _____ Phone _____

Preferred Hospital: _____

Signature of Parent or Legal Guardian _____ Date _____

Office Representative's Signature _____ Office Representative's Name (Print) _____

OFFICE USE ONLY: This authorization is effective from _____ to _____.