



Active feet are happy feet.

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Se Habla Español



Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____

Date of Birth: _____

Insurance Co. and ID # _____

I certify that I am the parent and/or legal guardian of: _____

I authorize _____ to bring my child to an office visit

in place of me on _____

I give this person permission to authorize and sign consents for office based treatment if needed.

My child's relationship to this person: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone # _____

Witness Signature: _____ Date: _____

Additional comments: _____
