

Carolina Physical Therapy and Sports Medicine, Inc.  
**MINOR CONSENT FORM**

I authorize Carolina Physical Therapy and Sports Medicine to treat  
\_\_\_\_\_ as ordered by his/her physician.

I authorize the physical therapist to make appropriate changes and advancement in  
treatment as indicated.

I also understand that the facility closes at 6:00 p.m. (M-F) and I am responsible for  
having my minor picked up by this time. I understand that there will be no staff  
member after 6:00 p.m. to supervise my child.

Parent/Guardian \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_