

Authorization to Treat a Minor

This consent shall remain effective until unenrolled by parent.

I (we) the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed, of a licensed dentist, and on the staff of any acute general hospital holding a current license to operate a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____ (cont. on back if necessary)

Signature of Father, Mother, or Legal Guardian:

_____ Date: _____

_____ Date: _____

Child's
Birth Date: _____ Last Tetanus Booster: _____

Allergies to Drugs or Food:

Any Special Medications or Pertinent Information:

Preferred
Hospital: _____ Phone: _____

Child's Physician:
_____ Phone: _____

Insurance Company and Policy Number:
