SAMPLE AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____,_____

I the undersigned parent, parents or legal guardian of _____, 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 under the provisions of the Medicine Practice Act , of a Dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of _____ Department of Public Health. 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: _____

_____

Signature of
Legal Guardian: _____Date:_____

Address:_____ City:_____ State:_____ Zip:_____

D.O.B.:_____

Last Tetanus Toxoid Booster:
_____

Allergies to Drugs or Foods:
_____

Any Special Medications
Or Pertinent
Information:_____

_____

Telephones Where Parents May Be Reached

Parent:_____ _____ Home:_____ Work:_____

Parent:_____ Home:_____ Work:_____

Family Physician:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Insurance Company: _____Policy No. _____