AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

Date: _____ I/We, the undersigned, parent(s)/guardian(s) of

_____

(print full name of minor)

a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the supervision of any licensed physician/surgeon, whether such accredited treatment is rendered at the office of the physician or at YOUR HOSPITAL.

I/We, understand 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 on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which aforementioned physician/surgeon in the exercise of his/her judgment may deem advisable.

These authorizations shall be in effect until _____.

Date

_____

Signature of parent/guardian

_____

Signature of parent/guardian

_____ _____

Address Phone

_____ _____ _____

City State Zip code

_____

Minor's DOB: _____ Blood type: _____

Date of last tetanus shot: _____ Allergies: _____

Special medications or medical problems: _____

Family physician and phone: _____

Medical insurance carrier: _____

Policy number, agent: _____