AUTHORIZATION TO TREAT A MINOR

(I)(We), the undersigned parent(s) or legal guardian(s) of ______________________, a minor, do hereby authorize (name of coach or team representative-not to exclude others who may bring my child in for emergency treatment)___________________________________ as agent(s) for the undersigned to 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 general or specific supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of this hospital or emergency clinic.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required; but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain in effect indefinitely or until revoked in writing.

Child's Name:____ Phone:__________________

Address:_________________________ City:_______________ State:______ Zip:____________

Birthdate:______________________ Last Tetanus/Diphtheria booster:___________________

School:____ Grade:______________________

Family Physician:___________________________________ Phone:______________________

Allergies to drugs or foods:____

Any special medications or pertinent information_____________________________________

____

Insurance Company:______________________________ Policy No:__________________

Employer:____

Parent/Guardian Address (if different from child)______________________________________

City:________________ State:______________ Zip:___________ Phone:_________________

Other phones where parent(s)/guardian(s) may be reached:

Name:_________________________ Phone:___________________ Where:_______________

Name:_________________________ Phone:___________________ Where:_______________

Authorization (please sign):

Name:_____________________________ Relationship:_________________ Date:___________

Name:_____________________________ Relationship:_________________ Date:___________