

## AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR CHILD

We, the understated, parents/guardian of: \_\_\_\_\_, a minor, do hereby consent to any emergency x-ray examination, anesthetic, medical or surgical diagnosis of treatment and hospital service that may be rendered to said minor (under 18 years of age) under the general or special instructions of any physician and surgeon licensed hospital or emergency care facility, whether rendered at the office of said physician or at the licensed hospital or emergency care facility. It is understood that this consent is given in advance to encourage youth leaders, staff, event coordinators, and said physicians to exercise best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain effective through August 30<sup>th</sup>, 2009 unless sooner revoked in writing delivered to said physician or said persons entrusted with custody of said minor.

### FAMILY INFORMATION

DATE \_\_\_\_\_

FATHER/GUARDIAN'S NAME \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME/CELL PHONE \_\_\_\_\_

SIGNATURE  \_\_\_\_\_

DATE \_\_\_\_\_

MOTHER'S/GUARDIAN NAME \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME/CELL PHONE \_\_\_\_\_

SIGNATURE  \_\_\_\_\_

EMERGENCY CONTACT OTHER THAN PARENT \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

PHONE \_\_\_\_\_

### STUDENT INFORMATION

GENDER  MALE  FEMALE

ADDRESS OF MINOR \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE OF MINOR \_\_\_\_\_ GRADE \_\_\_\_\_

### MEDICAL INFORMATION

DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

CLINIC ADDRESS \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ PHONE \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

IS THERE ANY INFORMATION OF WHICH THE PERSONS RESPONSIBLE SHOULD BE AWARE?  
(allergies, medications, etc.)