

AUTHORIZATION FOR TREATMENT TO MINOR

I/we the undersigned parent(s) or legal guardian of the minor listed below:

_____ Birth Date _____
(Minor's Name)

do hereby authorize any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State and hospital service that may be rendered to said minor under the general, specific, or special consent of Matthew McCready, or Danny Cole, or Jara Lipperd, or Alan Muggenborg, or Rachel Phillips, or Terri Tomlinson, or Charles Pisarra the temporary custodian of the minor, whether such diagnosis or treatment is rendered at the office of the physician or dentist or at a hospital licensed by the State. I/we authorize the physician or dentist to call in any necessary consultants at his/her discretion. I/we further authorize said physician or dentist to exercise his/their discretion in authorizing the disposal of any severed tissue(s) or member(s).

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage those persons who have temporary custody of the minor, and said physician or dentist, to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

This consent shall remain effective until 12:01 a.m. on the 31st day of August, 2007, unless sooner revoked in writing, delivered to said physician or dentist or said persons entrusted with the custody, cure, and control of said minor child.

Dated _____
Father Signature _____

Witness: (Other than Custodian) _____
Mother Signature _____

_____ or Legal Guardian Signature

Date of last Tetanus shot _____

Allergies to medication _____

Other allergies _____

List any medication (s) minor is taking regularly _____

What medications can your child take for minor pain, headaches, cold, cough, etc.. _____

List any medical condition minor has that may require treatment, i.e., heart condition, seizure disorder, asthma, hayfever, arthritis, migraine headaches, colitis, joint problems (back, knee, ankle, etc.).

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship to patient _____

Address _____ Home Phone _____ SS# _____

Employer _____ Employer's Address _____

Business Phone _____ Driver's License # _____

Emergency phone number _____

POLICYHOLDER INFORMATION

Name of Policyholder _____ ID # _____ Group # _____

SS# _____ Date of Birth _____

Insurance Company _____ Phone No. of Insurance Co. _____

Claims Mailing Address _____

My Commission Expires _____ Notary Public _____ Dated _____