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 Mueggenborg, or Rachel Phillips, or Ted Bachmann, or Charles Pisarra, or Rod Mackey, or Geoff Webb, or Trey Pritner 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, 2008, 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 __________________________