Authorization for Consent to Treat a Minor

I, _____, hereby authorize _____ to consent to obtain
(name and relationship to minor) (name of person authorized to consent)

the following medical treatment for _____:
(name of minor)

(Please check one) _____all surgical and medical treatment; OR _____ only the surgical and/or medical

treatment listed below:

(Specify treatment) _____

The authorization shall be limited to the following time period:

_____.

If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature _____ Date _____

(must be signed by parent or legal guardian)

To be completed for each child.

Child's birth date _____ Name and phone number of child's physician _____

Address and phone number where parents can be reached _____

Additional information that may be helpful in treating your child _____

_____

Medical History (list any chronic or existing diseases or medical problems, allergies, etc.) _____

_____

Medicines your child is taking now (name, dosage & frequency)

_____

Child's dentist _____

Medical insurance company (attach copy of insurance card) _____

Policy holder name _____ Policy holder DOB _____

Policy holder ID _____ Member's Employer _____Policy No._____