Authorization for Consent to Treat a Minor

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

obtain 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 ______________________________ Clergyman ______________________________

Medical insurance company (attach copy of insurance card) ______________________________

Policy holder name ______________________________ Policy holder DOB ______________________________

Policy holder ID ______________ Member's Employer ______________ Policy No. ______________