CONSENT FOR MEDICAL TREATMENT OF MINORS AUTHORIZATION FORM

Authorization & Consent of Parent(s) or Legal Guardian(s)

I, _____, am the parent or legal guardian of _____, a Minor. I hereby give my consent and authorization for medical care rendered to the Minor, including emergency and non-emergency diagnostic procedures and surgical and dental care. I further voluntarily consent and authorize _____ (hereinafter "Caregiver") to administer treatment for any basic injuries or illnesses experienced by the Minor. If the injuries or illnesses experienced are more serious, I consent to and authorize the Caregiver to take appropriate measures, including summoning emergency medical personnel and the authority to issue consent for necessary medical care as deemed by any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. This includes any X-ray, anesthetic, blood transfusion, medication, or any other medical treatment.

In making medical decisions on my behalf for the benefit of the Minor, I direct the caregiver to attempt to contact me. Additionally, I authorize the health care provider to discuss in full with the Caregiver any medical information that is required to help the treatment of the Minor. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of the Minor and that I assume financial responsibility for such medical care.

It is understood that this authorization is given in advance of any such medical treatment, but it is given to provide authority and power on the part of the Caregiver in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed, this _____ day of _____, 20___

This authorization is effective through ___ / ___ / _____

_____ Printed Name of Parent/Legal Guardian

_____ Printed Name of Witness

_____ Signature of Parent/Legal Guardian

_____ Signature of Witness

_____ Primary Phone of Parent/Legal Guardian

_____ Work Phone of Parent/Legal Guardian

Minor's Pertinent Health Information

_____ Minor's Full Legal Name

_____ Medications

_____ Minor's Date of Birth

_____

_____ Home Address

_____ Allergies

_____ City, State ZIP

_____

_____ Health Insurance Carrier

_____ Date of Last Tetanus Shot

_____ Health Insurance Policy # & Group #

_____ Other Pertinent Medical History