AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR A MINOR

I/We ____ do hereby state that I am/we are the natural parent(s)/leagal guardian(s) having legal custody of _______________________________ a minor, age _______ years old, born ____/____/____, who resides with me/us.
I/We authorize ___________________________ to consent to am X-ray examination, anesthetic,
(Name of Advisor)
medical or surgical diagnosis or treatment , and hospital care to be rendered to the minor under the general or special supervision and on the advice of any licensed physician or surgeon when the need for such treatments is immediate, and when efforts to contact me/us are unsuccessful.

___________________________________ ____/____/____

SUPPLEMENTARY DATA:

Parents' Phone Home ____________ Work _____________

Parents' Address Address ____

Name and Address of Child's Doctor ____

____

Phone _____________

Name and Address of Parent's Doctor ____

____

Phone ______________

Child's Allergies (if any) ____

Child's Medical Allergies (if any) ____

Medications child is taking (if any) ____

Date of last Tetanus shot ___________

Choice of specialists (if any) ____

INSURANCE DATA:

Company _____________________________________ Agreement # _____________________

Group # ______________________________________ Plan Code # _____________________

Additional medical information which may be helpful to attending physician:

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Do you wish to be contacted in the event of a minor illness or injurty? YES NO