



AUTHORIZATION TO TREAT A MINOR

(I) (We), the undersigned parent(s) or legal guardian(s) of _____ a minor, do hereby authorize (name of coach or team representative—not to exclude others who may bring my child in for emergency treatment) _____ as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of this hospital or emergency clinic.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required; but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnoses, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain in effect indefinitely or until revoked in writing.

Child's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Last Tetanus/Diphtheria Booster _____

School _____ Grade _____

Family Physician _____ Phone _____

Allergies to Drugs or Foods _____

Any Special Medications or Pertinent Information _____

Insurance Company _____ Policy No. _____

Employer _____

Parent/Guardian Address (if different from Child) _____

City _____ State _____ Zip _____ Phone _____

Other Phones where parent(s)/guardian(s) may be reached:

Name _____ Phone _____ Where _____

Name _____ Phone _____ Where _____

Authorization (please sign):

Name _____ Relationship _____ Date _____

Name _____ Relationship _____ Date _____