AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR FORM

PART I. Identification

I/We, (Parents) _____ of (address)_____
are the (Parents /Guardians) _____ of _____.

PART II. Authorization

We authorize_____ to consent to x-ray, examination, anesthetic, hospital care, medical or surgical diagnosis or treatment to be rendered to _____ when the need for such care is immediate and when efforts to contact us are unsuccessful.

PART III. Duration

We understand this authorization is valid from _____(or for other dates as entered below and initialed by the parents).

Signature:_____ Date_____

Other authorized dates: _____, Initials _____
_____, Initials _____
_____, Initials _____
_____, Initials _____
_____, Initials _____

Part IV. Information

Birth date: ___/___/____

Physician _____(___) _____
Insurance – Medical _____(___) _____

Dentist _____(___) _____
Orthodontist _____(___) _____
Insurance – _____(___) _____

Last Tetanus Shot _____ **Allergies** _____ **Medicines** _____
Existing Medical Conditions _____

Father's Home phone: ____-____-_____ **Father's Work phone:** ____-____-_____
Father's Cell phone: ____-____-_____ **Father's Email:** _____

Mother's Home phone: ____-____-_____ **Mother's Work phone:** ____-____-_____
Mother's Cell phone: ____-____-_____ **Mother's Email:** _____

Father's signature: _____ **Date** _____
and/or
Mother's signature: _____ **Date** _____

Other information (timing of medicines, special instructions,…)
_____
_____
_____
_____