

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. _____