AUTHORIZATION TO TREAT A MINOR

(I) / (We), the undersigned, parent(s) or legal guardian of _____ a minor, do hereby consent to any X-ray examinations, and hospital care which is deemed advisable by, and is suggested, recommended, prescribed or directed by any physician or surgeon duly licensed to practice in the State of Georgia.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached.

This authorization shall remain in effect until July 31, 2019, unless sooner revoked in writing delivered to said agent(s).

CHILD'S NAME: _____ PHONE: _____
ADDRESS: _____
BIRTHDATE: _____ LAST TETANUS/DIPTHERIA BOOSTER: not required
SCHOOL: _____ GRADE: _____
ALLERGIES TO DRUGS OR FOOD: _____
_____
ANY SPECIAL MEDICATION OR PERTINENT INFORMATION: _____
_____

PARENT OR LEGAL GUARDIAN: (PRINT) _____
ADDRESS: _____
EMPLOYER: not required
ADDRESS: not required

TELEPHONES WHERE PARENTS OR GUARDIAN MAY BE REACHED:

FATHER'S NAME: _____ Business Phone: _____
MOTHERS'S NAME: _____ Business Phone: _____
LEGAL GUARDIAN: _____ Business Phone: _____
FAMILY PHYSICIAN: _____ Business Phone: _____

AUTHORIZATION (Please Sign): _____

☐ **NO, I DO NOT WISH TO SIGN THIS AUTHORIZATION.**

DATE: _____
WITNESS: _____
WITNESS: _____

PLEASE RETURN THIS FORM TO YOUR COACH AS SOON AS POSSIBLE. THIS AUTHORIZATION IS FOR THE COACH TO KEEP WITH THEM AT ALL TEAM FUNCTIONS IN CASE OF EMERGENCY. DO NOT TURN THIS FORM IN TO ANY OF THE RECREATION CENTER OFFICES.