

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 _____, 20____, unless sooner revoked in writing delivered to Said agent(s).

CHILD'S NAME: _____ PHONE: _____
ADDRESS: _____ ZIP: _____
BIRTHDATE: _____ LAST TETANUS/DIPHTHERIA BOOSTER: _____
SCHOOL: _____ GRADE: _____
ALLERGIES TO DRUGS OR FOOD: _____

ANY SPECIAL MEDICATION OR PERTINANT INFORMATION: _____

PARENT OR LEGAL GUARDIAN (Print): _____

ADDRESS (If different from child's): _____

EMPLOYER: _____

ADDRESS: _____ ZIP: _____

TELEPHONES WHERE PARENTS OR GUARDIAN MAY BE REACHED:

FATHER'S NAME: _____ BUSINESS PHONE: _____

MOTHER'S NAME: _____ BUSINESS PHONE: _____

LEGAL GUARDIAN: _____ BUSINESS PHONE: _____

FAMILY PHYSICIAN: _____ BUSINESS PHONE: _____

AUTHORIZATION (Signature): _____

NO! I do not wish to sign this authorization and do not authorize treatment by anyone for my child

DATE: _____

WITNESS: _____

WITNESS: _____

IT IS MANDATORY THAT THIS FORM BE TURNED IN BEFORE YOUR CHILD PARTICIPATES IN THIS PROGRAM. THE PROGRAM STAFF WILL KEEP THESE FORMS WITH THEM IN CASE OF EMERGENCY.