

Authorization for Medical Care of a Minor

I, _____ the undersigned parent or person having legal custody or the legal guardian
(please print name)
of _____ do hereby authorize _____
(please print minor's name) (name of person to whom child is entrusted)

TO CONSENT TO any x-ray examination, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above minor under general or special supervision and upon the advice of a physician, surgeon or dentist licenses under the laws of the state of _____ IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; In such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatments from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health and safety of the above named minor.

_____ (date) _____ (signature of parent or person having legal custody or legal guardian) _____

_____ (address) _____ (state) _____ (city) _____ (zip code)

Treatment Information:

Minor's Birth Date _____ Minor's Allergies _____

Minor's Doctor _____ (name) _____ (phone)

Other Doctor _____ (name) _____ (phone)

Medicine Minor is Taking _____ (name) _____ (phone)

Date of Minor's Last Tetanus Shot _____

Minor's Medical History _____

Hospital Emergency Preference (if circumstances allow) _____