

### Authorization for Consent to Treat a Minor

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to consent to obtain  
(name and relationship to minor) (name of person authorized to consent)

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 \_\_\_\_\_

Medical insurance company (attach copy of insurance card) \_\_\_\_\_

Policy holder name \_\_\_\_\_ Policy holder DOB \_\_\_\_\_

Policy holder ID \_\_\_\_\_ Member's Employer \_\_\_\_\_ Policy No. \_\_\_\_\_