AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until_____, 20_____

I (we) the undersigned parent, parents or legal guardian of _____ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical treatment rendered under the general or special supervision of any member of the medical staff at Gahanna Primary Care. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

_____

_____

Signature of Father, Mother or Legal Guardian: _____ Date: _____

Address: _____ City: _____ State: _____

ZIP: _____

Birth Date: _____

Allergies to drugs or foods: _____

Any special medications or pertinent information: _____

_____

_____

Phone numbers where parents may be reached:

Father: _____

Home: _____ Work: _____ Cell: _____

Mother: _____

Home: _____ Work: _____ Cell: _____

Insurance Company: _____ Policy No: _____