AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _______________________.

I, the undersigned parent, parents or legal guardian of ___________________, minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act, of a Dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Ohio, Indiana, or Kentucky Department of Public Health. 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/her best judgment may deem advisable. 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 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:____
Last Tetanus Toxoid
Booster:____
Allergies to Drugs or
Foods:____
Any Special Medications or Pertinent
Information:____
____
Telephone Where Parents May Be Reached
Father:____________________Home:____________________Work:______________
Mother:____________________Home:____________________Work:_____________
Family Physician:____
Address:______________________________City:___________State:____Zip:_____
Phone Number: ____
Insurance Company:____
Policy No.______________________________________