MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care of a minor. This is extremely important, in that, medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

Minor's Full Name_____

Minor's Address_____

City, State, Zip Code_____

Minor's Age_____

The undersigned do hereby authorize_____or such substitute as he/she may designate as agent for the Undersigned to consent to any radiology, anesthetic, medical, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/ or surgeon, licensed under the Provision of Medicine Practice Act, whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or elsewhere.

Parent or Guardian Signature_____Date_____

Parent or Guardian Print Name_____

Address Parent or Guardian_____

Home and Work Phones of Parent or Guardian_____

Witness_____

Insurer_____Account Number_____

Family Physician_____

Family Physician's Full Address_____