(I, we), the undersigned, parent(s) or legal guardian of _____,
a minor, do hereby authorize, (insert name(s) or persons)

(1) _____ Address_____

Phone _____

(2) _____ Address_____

Phone _____

as agents for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general supervision of a duly licensed physician, whether such diagnosis or treatment is rendered in the office of said physician or at a hospital.

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 on the part of the aforesaid person(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and that said person(s) assumes no financial responsibility for exercising the action.

Parent or Legal Guardian _____ _____
Please Use Ink Print Complete Name Signature

Address _____

Home Phone _____Business Phone _____

Applicable Dates _____

Physician _____

Address _____

Phone _____

Date _____

Are there any medical conditions that may affect your child's health? (ex: epilepsy, diabetes)

Does your child take any medication? _____
If so, please give the name of the medication, reason for giving it and any possible reactions.

Does you child have any allergies? _____
If so, please list the specific allergy.

INSURANCE INFORMATION

Blue Cross/Blue Shield Group Number _____

Plan Number _____Soc. Sec. #_____

Location/Address:_____

Other Insurance: Policy Number_____

Company _____

Address _____

Bill to: _____

Address: _____