GOBLES PUBLIC SCHOOLS
MEDICAL TREATMENT CONSENT FORM

TO: Any Hospital, Clinic or Physician

Authorization to Treat a Minor Form

I, (We) the undersigned parent, parents or legal guardian of
_____ (minor name)

Authorize any hospital or clinic or licensed physician to treat my/our child, charge with any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital/clinic or office of a licensed physician.

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 when the physician in the exercise of his best judgment, may deem advisable. It is understood that an effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

_____

(Signature of Parent/Guardian) (Phone/Contact #)

If parent/guardian cannot be reached in an emergency call:

_____

(Contact Name) (Phone/Contact #)

Name and relationship to child:

List any restrictions to your authorization to treat:

Date minor received last tetanus/diphtheria booster:

List any allergies to drugs or food minor may have:

Any special medications or other pertinent information on minor:

_____

Family Physician (Phone/Contact #)

Preferred Hospital: _____