AUTHORIZATION TO TREAT A MINOR

Player's Name: _____

Address: _____

_____

Birthdate: _____

Name: Mother/Guardian _____ Father/Guardian _____

Home Phone: Mother/Guardian _____ Father/Guardian _____

Work Phone: Mother/Guardian _____ Father/Guardian _____

When was your last Tetanus Toxoid Booster.....? _____

Do you have any allergies.....?_____

Do you have any physical impairments.....? _____

If yes, state condition

_____

List any special medications or pertinent information: _____

_____

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy No.: _____

I (we) the undersigned parent(s) or legal guardian(s) of _____, a 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 or 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 Department of Public Health. It is understood that this authorization is given in advance of any specific diagnoses, 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 their 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. This authorization is given pursuant to the provisions of the civil code in your home state.

List Any Restrictions: _____

This consent shall remain in effect until: _____

_____/_____/____

Signature(s) of the Parent(s) or Guardian(s) Date