City of Mountain Park

AUTHORIZATION TO TREAT A MINOR

I/We, the undersigned, parent(s) or legal guardian of _____ a minor, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment or procedures and hospital care which is deemed advisable by, and is suggested, recommended, prescribed or directed by any physician or surgeon duly licensed to practice in the State of Georgia.

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 treatments will not be withheld if the undersigned cannot be reached.

This authorization shall remain in effect until October 1, 20_____, unless sooner revoked in writing delivered to said agent(s).

Child's Name_____

Address_____

Birthdate_____ Age_____ Last Year in School_____

School Attended_____

Date of Last Tetanus/Diphtheria Booster:_____

Allergies to Drugs, Foods, Others: _____

_____

Any Special Medications or Pertinent Information: _____

_____

Family Physician: _____ Phone #_____

Telephone Numbers Where Parents and/or Guardian May Be Reached:

Home Phone Number _____

Mother's Name _____ Cell #_____

Work #_____

Father's Name _____ Cell #_____

Work #_____

Legal Guardian _____ Cell #_____

Work #_____

Authorization: _____ Date _____

Signature of Parent or Legal Guardian

Witness: _____ Date_____