

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 _____ CITY _____
BIRTHDATE _____ AGE _____ LAST YEAR IN SCHOOL _____
SCHOOL ATTENDED _____

LAST TETANUS/DIPHTHERIA BOOSTER: _____
ALLERGIES TO DRUGS, FOOD, OTHERS: _____

ANY SPECIAL MEDICATION OR PERTINENT INFORMATION: _____

FAMILY PHYSICIAN: _____
PHONE: _____

TELEPHONE NUMBERS WHERE PARENTS OR GUARDIAN MAY BE REACHED:

HOME PHONE NUMBER _____

MOTHER'S NAME _____ WORK # _____

PAGER# _____

FATHER'S NAME _____ WORK# _____

PAGER _____

LEGAL GUARDIAN _____ WORK# _____

PAGER# _____

Date: _____

AUTHORIZATION _____

Witness: _____

Signature of Parent or Legal Guardian