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: ______________________________

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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 ______________