AUTHORIZATION TO TREAT A MINOR

I / we, the undersigned parent(s) or legal guardian of _________________________, a minor, do hereby consent to an X-ray examination, anesthetic, medical or surgical diagnosis, treatment or procedures and hospital care which is deemed advisable by, or 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 September 2010

CHILD'S NAME: _________________________________ PHONE: _________________

ADDRESS: ____

BIRTHDATE: ____

ALLERGIES TO DRUGS OR FOOD: ____

ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION: ___________________

____

PARENT OR LEGAL GUARDIAN: ____

ADDRESS: ____

TELEPHONES WHERE PARENTS MAY BE REACHED:

FATHER'S NAME: _____________ HOME # ______________ WORK # ________________

MOTHER'S NAME: _____________ HOME # ______________ WORK # ________________

FAMILY PHYSICIAN: _______________________ PHONE # _________________

INSURANCE COMPANY NAME: ____

POLICY/ACCOUNT NUMBER: ____

AUTHORIZATION (PLEASE SIGN)

FATHER: ___________________________________ DATE: _________________

MOTHER: ___________________________________ DATE: __________________

GUARDIAN: _________________________________ DATE: __________________

__________ NO, I DO NOT WISH TO SIGN THE AUTHORIZATION