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 June 2015

CHILDS NAME: _____

ADDRESS: _____

BIRTHDATE: _____ALLERGIES TO DRUGS OR FOOD: _____

ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION:

_____

PARENT OR LEGAL GUARDIAN(S):

_____

ADDRESS:_____

TELEPHONES WHERE PARENTS/GAURDIAN MAY BE REACHED:

FATHERS NAME: _____ CELL# _____

MOTHERS NAME: _____ CELL# _____

FAMILY PHYSICIAN: _____ PHONE# _____

INSURANCE COMPANY NAME: _____

POLICY/ACCOUNT NUMBER: _____

AUTHORIZATION (PLEASE SIGN)

PARENT: _____ DATE: _____

GUARDIAN: _____ DATE: _____

_____ NO, I DO NOT WISH TO SIGN THE AUTHORIZATION
This message was sent via the Jaguar Sports Association website.