

**AUTHORIZATION TO TREAT A MINOR**



I, the undersigned parent or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital or clinic. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care that the aforementioned physician in the exercise of best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: \_\_\_\_\_

I hereby authorize and consent to the examination and/or treatment of minor illness or injury that might occur while at a school activity, by a licensed M.D., D.O., or R.N., who, from time-to-time, would be in attendance as a first-aid provider for that activity.

I hereby authorize and consent to the following over-the-counter medication being dispensed to my minor child by the MVHSIMBA Managers:  Benedryl;  Tylenol;  Advil;  Tums;  Sudafed; Other: \_\_\_\_\_

I hereby authorize and consent to the MVHSIMBA Managers dispensing the following prescription medication(s) to my minor child : \_\_\_\_\_ . I will give the prescription medication(s) to the MVHSIMBA Managers in a zip-lock bag clearly marked with my child's name; with written dispensing instructions and any pertinent information inside the bag. Dispensing of any medications, whether over-the-counter or prescription, will be done in a confidential manner.

Birthdate: \_\_\_\_\_ Last Tetanus Toxin Booster: \_\_\_\_\_

Allergies to drugs or foods: \_\_\_\_\_

Any special medications or pertinent information: \_\_\_\_\_

Father's Name (please print) \_\_\_\_\_

Mother's Name (please print) \_\_\_\_\_

Telephone numbers where parent(s) may be reached:

Father: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Mother: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State CA Zip \_\_\_\_\_

Family Physician's Name and Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Signature of Mother, Father or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

This consent shall remain effective until \_\_\_\_\_ (month/year)