

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 2017

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.

Please reply with UNSUBSCRIBE in the subject line to be removed from future mailings.v1.1