FOR TREATMENT OF MINORS

IN THE EMERGENCY/OUTPATIENT DEPARTMENT

AND HIGH SCHOOL ATHLETIC DEPARTMENT

In the event that I am unavailable for purposes of providing parental consent, I hereby authorize the physician(s) and staff in the Emergency/Outpatient Department of the treating hospital to provide such hospital care that includes routine diagnostic procedures and medical treatment as necessary to my minor son/daughter.

Student's Name: _____

I also hereby authorize the Athletic Training and coaching staffs to provide any emergency first aid care as is deemed necessary.

I understand that the consent and authorization herein granted does not include major surgical procedures.

This consent is valid for one year from the date indicated below. A photocopy of this authorization shall be considered as effective and valid as the original.

Physical conditions of the minor noted above that the physician should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, medications, and date of last immunizations, etc.)

Allergies: _____

Medications: _____

Other: _____

I understand that I will be contacted as soon as possible in the event that my child is brought to the hospital for treatment. If I am not available, please contact:

Name: _____ Phone: _____

I also consent to the release of a report containing diagnoses and other medical information related to the examination and treatment of the above patient to such agencies, including insurance companies, as might be concerned with payment of charges for hospital services.

_____ _____

Insurance Provider Parent/Guardian Signature

_____ _____ _____

Policy Number Date Relationship

_____

Address

_____

_____

Telephone: Work/Home