



***RETURN TO:
COACH/MANAGER***

AUTHORIZATION TO TREAT A MINOR

(I) (We), the undersigned, parent(s) or guardians of _____ a minor, do hereby authorize (name(s) of primary caretakers, such as babysitter, relatives-not to exclude others who may bring my child in for emergency treatment)

_____ as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of, any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of hospital.

It is understood that this authorization is given in advance of any specific diagnosis of hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain in effect indefinitely or until revoked in writing to the hospital.

CHILD'S NAME _____ PHONE _____

ADDRESS _____

BIRTHDATE _____

LAST TETANUS/DIPHTHERIA BOOSTER _____

SCHOOL _____ GRADE _____

ALLERGIES TO DRUGS OR FOOD _____

ANY SPECIAL MEDICATIONS OR PERTINENT INFORMATION _____

INSURANCE COMPANY _____ POLICY NO. _____

PARENTS OR LEGAL GUARDIAN _____

Last First Middle

ADDRESS _____

EMPLOYER _____

ADDRESS _____

TELEPHONES WHERE PARENTS MAY BE REACHED...

FATHER'S NAME _____ PHONE _____

MOTHER'S NAME _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

AUTHORIZATION (please sign)

FATHER _____ DATED _____

MOTHER _____

LEGAL GUARDIAN (If Applicable) _____