

# AUTHORIZATION TO TREAT A MINOR

(I) / (We), the undersigned, parent(s) or legal guardian of \_\_\_\_\_ a minor, do hereby consent to any X-ray examinations, and hospital care which is deemed advisable by, and 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 \_\_\_\_\_, 20\_\_\_\_, unless sooner revoked in writing delivered to said agent(s).

CHILD'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ LAST TETANUS/DIPHTHERIA BOOSTER: \_\_\_\_\_  
SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_  
ALLERGIES TO DRUGS OR FOOD: \_\_\_\_\_

ANY SPECIAL MEDICATION OR PERTINENT INFORMATION: \_\_\_\_\_  
\_\_\_\_\_

PARENT OR LEGAL GUARDIAN: (PRINT) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**TELEPHONES WHERE PARENTS OR GUARDIAN MAY BE REACHED:**

FATHER'S NAME: _____	Business Phone: _____
MOTHERS'S NAME: _____	Business Phone: _____
LEGAL GUARDIAN: _____	Business Phone: _____
FAMILY PHYSICIAN: _____	Business Phone: _____

**AUTHORIZATION (Please Sign):** \_\_\_\_\_



**NO, I DO NOT WISH TO SIGN THIS AUTHORIZATION.**

DATE: \_\_\_\_\_  
WITNESS: \_\_\_\_\_  
WITNESS: \_\_\_\_\_

***PLEASE RETURN THIS FORM TO YOUR COACH AS SOON AS POSSIBLE. THIS AUTHORIZATION IS FOR THE COACH TO KEEP WITH THEM AT ALL TEAM FUNCTIONS IN CASE OF EMERGENCY. DO NOT TURN THIS FORM IN TO THE RECREATION DEPARMENT OFFICE.***