Medical Authorization for Minors

I, _____, the parent of or legal guardian of _____, a minor, do hereby authorize any one or more of _____,_____ _____,_____, as agents for myself in my absense or incapacitation to consent to any x-ray examination and anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and it to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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 on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

I hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to the above-named agents upon the completion of treatment.

These authorizations shall remain effective until _____,_____.

Signature of Parent or Legal Guardian:_____

Copies of this form, duly executed, should be in the possession of the named minor; at least one adult named in this document and present at the event; and in the parent or guardian executing the Medical Authorization.

Please note any specific healthy plan or insurance information such as membership or policy numbers below: A copy of the insurance card front and back is sufficient.

Insured:_____
Policy #:_____

Insured Address and Telephone #: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Telephone #: _____