(I, we), the undersigned, parent(s) or legal guardian of ________________________________,
a minor, do hereby authorize, (insert name(s) or persons)

(1) ________________________________ Address___________________________________

Phone ________________________

(2) ________________________________ Address___________________________________

Phone ________________________

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 supervision of a duly licensed physician, whether such diagnosis or treatment is rendered in the office of said physician or at a 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 person(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; and that said person(s) assumes no financial responsibility for exercising the action.

Parent or Legal Guardian _______________________________ ____________________________
Please Use Ink Print Complete Name Signature

Address ____

Home Phone ___________________________Business Phone ______________________________

Applicable Dates ____

Physician _______________________________________

Address ____

Phone ____________________________

Date _____________________________

Are there any medical conditions that may affect your child’s health? (ex: epilepsy, diabetes)

Does your child take any medication? ____
If so, please give the name of the medication, reason for giving it and any possible reactions.

Does you child have any allergies? ____
If so, please list the specific allergy.

INSURANCE INFORMATION

Blue Cross/Blue Shield Group Number ____

Plan Number ______________________________Soc. Sec. #__________________

Location/Address:____

Other Insurance: Policy Number____

Company ____

Address ____

Bill to: ____

Address: ____