AUTHORIZATION TO TREAT A MINOR

▢ I, the undersigned parent or legal guardian of ______________________________; a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special suervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital or clinic. It is understood that this authorization is give in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care that the aforementioned physician in the exercise of best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions (N/A if none)____

☐ I hereby authorize and consent to the examination and/or treatment of minor illness or injury that might occur while at a school activity, by a licensed M.S., S.O., or R.N., who, from time-to-time, would be in attendance as a first-aid provide for that activity.

☐ I hereby authorize and consent to the following over-the-counter medication being dispensed to my minor child by the MVHSIMBA Managers: ☐ Benedryl; ☐ Tylenol; ☐ Advil/Ibuprofen; ☐ Tums ☐ Sudafed; ☐ Midol

Other:____

☐ I hereby authorize and consent to the MVHSIMBA Managers dispensing the following prescription medication (s) to my minor child: ____

____

I will give the prescription medication (s) to the MVHSIMBA Managers in a Zip-loc bag in their original prescription container, clearly marked with my child's name, a written dispensing instruction and any pertinent information inside the bag. Dispensing of any medications, whether over-the-counter or prescription, will be done in a confidential manner.

Birthdate:______________________________ Last Tetanus Toxin Booster:____

Allergies to drugs or foods: ____

Any special medications or pertinent information:____

Father's Name (please print):____

Mother's Name (please print):____

Telephone numbers where parent (s) may be reached:

Father: Home_____________________ Father: Work____________________ Father: Cell_______________________________

Mother: Home_____________________ Mother: Work___________________ Mother: Cell_______________________________

____

Address City State Zip

Family Physician Name and Address:____

Name City Phone

Insurance Company:____

Name Address

____ ____

Policy number Phone Number

____

Signature of Mother, Father or Legal Guardian Date

This shall remain in effect until the end of the current school year, June 2, 2022 or ______________________________________