

Authorization to Treat a Minor

I, undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of a general hospital holding a current license to operate a hospital from the State of Arkansas Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospitalization required and is given to provide authority and power to render care which the aforementioned physician or dentist in his best judgment may deem advisable. It is understood that all 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.

I further grant permission to the administrator, teacher, or school secretary of Gospel Light Christian School to administer aspirin and/or Tylenol to my child during school hours only as need occurs. I further grant permission to give my child over the counter medicine as prescribed according to directions. I understand that from time to time it might become necessary for the school administration/staff to administer first aid treatment to my child.

Signature of Father, Mother or Legal Guardian

Restrictions:

Birth _____

Date of last Tetanus Diphtheria Booster _____

Drugs or foods: _____

Other medications or pertinent information? _____

Persons where parents may be reached:

Name	Home Number	Business Phone	Cell/Beeper
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Name	Home Number	Business Phone	Cell/Beeper
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Physician _____ Phone _____

Company _____

Member _____