

## Authorization to Treat a Minor

I (we), the 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 general or special 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 any acute general hospital holding a current license to operate a hospital from the State of Arkansas Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power to render care which the aforementioned physician in the exercise of 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 hereby grant permission to the administrator, teacher, or school secretary of Gospel Light Baptist School to give aspirin and/or Tylenol to my child during school hours only as need occurs. I further grant permission to give prescription 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.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Father, Mother or Legal Guardian

List of restrictions:

\_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of last Tetanus Diphtheria Booster \_\_\_\_\_

Allergies to drugs or foods: \_\_\_\_\_

Any special medications or pertinent information? \_\_\_\_\_

Telephones where parents may be reached:

_____	_____	_____	_____
Father's Name	Home Number	Business Phone	Cell/Beeper Number

_____	_____	_____	_____
Mother's Name	Home Number	Business Phone	Cell/Beeper Number

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_