

## AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/we the undersigned parent(s) or legal guardian of \_\_\_\_\_, a minor, do hereby authorize the Pilot Aquatic Club, officers, and coaches as agent for the undersigned to obtain medical treatment for the above child and to consent to X-Ray examination, anesthetic, medical or surgical diagnosis or hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of a licensed physician and/or surgeon under the provisions of the MEDICINE PRACTICE ACT or a licensed dentist under the provisions of the DENTAL PRACTICE ACT.

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 our aforesaid agent 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, deems advisable.

It is understood that 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 of the undersigned cannot be reached.

It is understood that I/we the undersigned are responsible for all charges for the above mentioned diagnosis, treatment or hospital care.

Name of Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

Last Tetanus Booster: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
**Parent or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**