

**City of Mountain Park**

**AUTHORIZATION TO TREAT A MINOR**

I/We, the undersigned, parent (s) or legal guardian of \_\_\_\_\_ a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment or procedures and hospital care which is deemed advisable by, and is suggested, recommended, prescribed or directed by any physician or surgeon duly licensed to practice in the State of Georgia.

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 treatments will not be withheld if the undersigned cannot be reached.

This authorization shall remain in effect until October 1, 20\_\_\_\_, unless sooner revoked in writing delivered to said agent (s).

CHILD'S  
NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ LAST YEAR IN  
SCHOOL \_\_\_\_\_  
SCHOOL  
ATTENDED \_\_\_\_\_  
LAST TETANUS/DIPHThERIA  
BOOSTER: \_\_\_\_\_  
ALLERGIES TO DRUGS, FOOD,  
OTHERS: \_\_\_\_\_

ANY SPECIAL MEDICATION OR PERTINENT  
INFORMATION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
TELEPHONE NUMBERS WHERE PARENTS OR GUARDIAN MAY BE REACHED:  
HOME PHONE NUMBER \_\_\_\_\_  
MOTHER'S NAME \_\_\_\_\_ WORK  
# \_\_\_\_\_  
PAGER# \_\_\_\_\_  
FATHER'S  
NAME \_\_\_\_\_ WORK# \_\_\_\_\_  
PAGER \_\_\_\_\_  
LEGAL  
GUARDIAN \_\_\_\_\_ WORK# \_\_\_\_\_  
PAGER# \_\_\_\_\_  
Date: \_\_\_\_\_ AUTHORIZATION \_\_\_\_\_  
Witness: \_\_\_\_\_ Signature of Parent or Legal Guardian