

AUTHORIZATION TO TREAT A MINOR

I the undersigned parent, parents or legal guardian of _____, minor, do hereby authorize and consent to the medical examination and treatment of my child by Edith Jones-Poland, M.D. or Sheri Wysocki, FNP.

It is understood that this authorization is given in advance of any specific diagnosis or treatment and is given to provide authority and power to render care which the aforementioned physician or nurse practitioner in the exercise of her best judgment may deem 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 necessary treatment will not be withheld if the undersigned cannot be reached. The undersigned parent also agrees to accept financial responsibility for charges incurred by their child during their examination and/or treatment rendered under this authorization.

This authorization shall remain in effect from the date signed until _____.
If no date given, authorization shall remain in effect for 90 days from the date signed.

Signature of Father, Mother or Legal Guardian: _____

Date Signed: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR CHILD:

Date of Birth: _____ Date of last Tetanus booster: _____

Allergies to Drugs or Foods: _____

Medications my child is taking: _____

Telephones where parents may be reached:

Father's name: _____

Father cell: _____ Home: _____ Work: _____

Mother's name: _____

Mother cell: _____ Home: _____ Work: _____