maccc

Medical and Counseling Care Center

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of

_____ _____ _____

Name *Date of Birth* *Social Security # (Optional)*

Give my consent for emergency and routine medical and/or surgical treatment of this minor at ACU Medical Clinic should his/her condition so require it per the judgment of an ACU healthcare provider. As long as the medical and/or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations/prohibitions, specify here:

_____

_____

_____

_____

_____

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

_____ _____

Signature (Parent or Guardian) *Date*

_____

Street Address

_____

City *State* *Zip Code*

_____

Home Phone *Work Phone*