

Taylor County Hospital
Authorization for Treatment of Minors

Name of Minor

Birth Date _____

Family Doctor _____

Name Address City, State, Zip Phone

Guardian or Parent Name _____

Address: Street Route _____

City

County

State

Zip

Phone _____

Home

Work

Date of last Tetanus Booster _____,

Hospitalization Ins. Name & # _____

This form gives my legal consent for treatment of my child. I understand the hospital will make every effort to contact me but will not delay any treatment. I do hereby state that I am (we are) the parent(s) and/or guardian(s) of the minor who resides with me (us) as listed above.

I (we) consent to any necessary examination, anesthetic, medical or surgical treatment, and/or hospital care to be rendered to the above named minor under the supervision and on the advice of a duly licensed physician, surgeon, or dentist, during the period of my (our) absence.

Guardian's or Parent's Signature(s): _____

Date _____

Witness: _____

Date _____