ARKANSAS DECA

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis of any member of the medical staff or emergency room staff licensed under applicable law of any hospital holding a current license to operate under applicable law. It is understood that this authorization is given to provide authority and power to render care which aforementioned physician in the exercise of his/her best judgment may deem advisable. It is further understood that an effort shall be made to contact the undersigned prior to rendering treatment to patient, but that in an emergency situation, necessary treatment will not be withheld if the undersigned cannot be reached.

List any restrictions _____

_____

This consent shall remain effective until _____ 20____

Allergies to drugs or foods: _____

Any special medications or pertinent information: _____

Telephone numbers where parents (guardians) may be reached:

Father		**Mother**	
_____	_____	_____	_____
Home	Business	Home	Business

Family Physician (name) _____

Address _____ Phone _____

Insurance Company _____ Policy No. _____

_____

(Signature of Father, Mother, or Legal Guardian) Date

_____

Address City State Zip

_____

ADVISOR SHOULD BRING WITH THEM TO CONFERENCE A COPY FOR EACH STUDENT