AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, the undersigned parent or guardian of _____, a minor, does hereby consent to any emergency X-ray, medical, or surgical treatment or hospital care which is deemed appropriate by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agents or organizations involved assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the provisions of the applicable Civil Code for the State of Maryland.

Family Doctor:_____Phone: _____

Student Address: _____

City:_____State:_____Zip: _____

Mother's Phone (H) _____ (W) _____ (cell) _____

Father's Phone (H)_____ (W)_____ (cell) _____

Persons (if parents can't be reached) to contact in emergency:

1. _____Relationship_____Phone _____

2. _____Relationship_____Phone _____

Existing medical or learning problems: _____

_____

Known Allergies (e.g. bee stings): _____

Health Insurance Policy Holder: _____

Plan and group number: _____

This authorization to consent to treatment of minor shall remain effective until revoked in writing.

Signature (parent or legal guardian) _____