Rev. 2/01

PARENT/GUARDIAN AUTHORIZATION FOR TREATMENT OF MINORS (Under age 18)

SECTION I – TREATMENT AUTHORIZATION

I authorize the provision of medical and/or hospital care deemed necessary for:
Name: ____ Male / Female
(First, Middle Initial, Last)
Social Security #: _________________________________ Date of Birth: ____________
In the event an illness or injury occurs during his/her volunteer service to the NSHE, I further authorize the following:
_____ I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment deemed necessary.
_____ I authorize all medical care units to release medical record information to the NSHE's workers compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the NSHE or insurance and hereby guarantee full payment to the physician or health care units.

SECTION II – PARENT/GUARDIAN INFORMATION

Name of Parent/Guardian: ____
First Middle Initial Last
Address: ____
(Street , City, State, Zip)
Home #: _________________________ Work #: ______________________________
Signature: _______________________________ Date: ______________________

SECTION III – PHYSICIAN/EMERGENCY CONTACT INFORMATION

Family Physician: _____________________________ Phone: _____________________
Emergency Contact: ___________________________ Phone: _____________________

SECTION IV – TO BE COMPLETED BY THE DEPARTMENT IN CASE OF INJURY OR ILLNESS

Date of Injury/Illness: ________________ Body Part Injured: _______________________
Nature of the injury: ____
Name of emergency contact person contacted: ______________________________________
Date of Contact: ____________________ Phone #: ____________________
Completed by : _______________________________ Extension: __________
(Print Name and Title)

Signature: __________________________________