AUTHORIZATION FOR CONSENT TO TREAT A MINOR

I, _____, hereby authorize
(name and relationship to minor)

Chadwick R-1 School District

_____ to consent to obtain
(name of person authorized to consent)

the following medical treatment for _____:
(name of minor)

(Please check one)

_____all surgical and medical treatment; OR

_____Only the surgical and/or medical treatment listed below:

_____.
(specify treatment)

This authorization shall be limited to the following time period:

_____.
(time period)

If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

_____ _____
Signature Date

CoxHealth

Patient Name:_____ Date of Birth:_____

NEEDS ASSESSMENT
PEDIATRIC

Date Completed:_____

Informant (Form Completed by)	Relationship to Child

Primary Language *(What language are you most comfortable speaking?)*

O English
O Spanish
O Other, specify which language

Do you have any spiritual, cultural or ethnic beliefs that you wish for us to know?	O yes	O no	If yes, specify

Do you have any physical or mental disabilities that require you to seek other's assistance in your child care? O yes O no If yes, specify:

Who is the child's legal guardian(s)?	Specify

Will a legal guardian come with your child for each visit? O yes O no
If no, a Minor's Consent for Treatment will be required for persons whom you authorize to accompany your child to any visit.
Ask staff for Consent for Treatment of Minors authorization.

List 3 phone numbers where we can contact you with questions or information	1 2 3