

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)

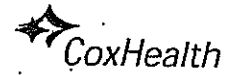
This authorization shall be limited to the following time period:

(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



Patient Name: _____ Date of Birth: _____

**NEEDS ASSESSMENT
PEDIATRIC**

Date Completed: _____

Informant (Form Completed by)	Relationship to Child
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Primary Language (What language are you most comfortable speaking?)

- English
- Spanish

Other, specify which language

Do you have any spiritual, cultural or ethnic beliefs that you wish for us to know?	<input type="radio"/> yes	<input type="radio"/> no	If yes, specify:
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Do you have any physical or mental disabilities that require you to seek other's assistance in your child care?	<input type="radio"/> yes	<input type="radio"/> no	If yes, specify:
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Who is the child's legal guardian(s)?	Specify:
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Will a legal guardian come with your child for each visit?	<input type="radio"/> yes	<input type="radio"/> no
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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