

CARY CHRISTIAN SCHOOL

AUTHORIZATION TO TREAT A MINOR FORM

I (We), the undersigned parent, parents or legal guardian of _____
Minor's Name

authorize any hospital or clinic or licensed physician to treat my/our child, charge with any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital/clinic or office of a physician who are licensed to practice in the State of North Carolina. 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 to render care when effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

Signature of Coach/Witness

Signature of Parent/Legal Guardian

Date Phone

Date Phone

List any restrictions to your authorization to treat: _____

Date minor received last tetanus/diphtheria booster: _____

List any allergies to drug(s) or food(s) minor may have: _____

Any special medication(s) or other pertinent information on minor: _____

This consent shall remain effective until the end of the minor's participation in:

_____ or until: _____

Expiration date

I give my consent for my child's coach to administer the following over-the-counter medications:

- Ibuprophen Acetaminophen Neosporin Benadryl (for allergic reaction only), Topical Hydrocortisone (for allergic reaction only) Other, please list below:
