AUTHORIZATION OF TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of _____, give my consent to Care United Medical Center, the physicians and other personnel on its medical staff, to administer such care, procedures and treatment that are deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state):

_____

School Name _____City _____ State _____

I understand that this authorization is good until the time in which the minor mentioned above reaches his/her 18th birthday.

Name: _____ (Relationship to patient) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature:_____ Date: _____

Care United Representative: _____