

HINSHAW PRESCHOOL
AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
SCHOOL YEAR _____

We, the undersigned parent(s) or guardian(s) of

_____, a minor, do hereby authorize adult workers with youth of the Hinshaw Preschool, as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Dated _____

Please Print Parent or Guardian _____

Parent or Guardian _____ SIGNATURE ONLY

Address _____ City _____

Telephone (Home) _____ (Office) _____

(Cell) _____ (Cell) _____

Other numbers for Emergency contact:

Names:

Numbers:

1. _____

2. _____

3. _____

List your pediatrician and any other physician in specialized fields that you would like to:

Pediatrician:

Number:

Other Specialists:

Number:
