X1352-0716

Pediatric Medical Authorization Form

PROXYMED

imprint

IF NOT ALREADY IN THE PATIENT'S MEDICAL RECORD THE RESPONSIBLE ADULT SHOULD BRING THIS COMPLETED FORM WITH THEM TO THE HOSPITAL OR DOCTOR'S OFFICE IF YOUR CHILD NEEDS MEDICAL CARE.

I, (We):

Name/Relation ____________ Address ____________ Phone # ____________

Name/Relation ____________ Address ____________ Phone # ____________

Authorize the following adult (over 18 years of age):

Name ____________ Address ____________ Phone # ____________

Name ____________ Address ____________ Phone # ____________

To consent to any necessary examination, x-ray, anesthetic, dental, medical, or surgical diagnosis or treatment and hospital care to be rendered to the below named minor child under the general or specific supervision, and on the advice of any physician, surgeon or dentist licensed to practice medicine, surgery or dentistry.

This authorization shall be in effect from ____________ to ____________ but not to exceed one year.
month/day/year month/day/year

Signature of parent or guardian ____________ Date ____________

Signature of parent or guardian ____________ Date ____________

Minor Child:

Name: ____________ Age: ____________ Date of Birth: ____________

Doctor's Name: ____________ Phone #: ____________

Identification/Policy #: ____________ Member's Name: ____________
(attach a photocopy of the insurance card if possible)

Medical History: ____________

Allergies (including medication allergies): ____________

Medications your child is taking now: ____________

Date your child received last Tetanus injection or booster: ____________