REGIONAL SERVICES

Authorization for Consent to Treatment of a Minor

Authorization is given to Drury University (Name of responsible adult) to consent to medical treatment for my child ______________ (Name of child) if I (we) the parent(s) or guardians are not available at the time of ______________ (Name of child)'s injury, illness or routine scheduled medical care. Authorization is also given to Drury University (Name of responsible adult) to authorize admission to the hospital for my child if in my (our) absence admission to the hospital is recommended by our private physician or a consulting physician of his/her choice due to injury or illness. I (we) accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authority.

July 7-18, 2019

Time frame for use of this consent: ______________ (If no date indicated, effective for 12 months from date below)

Child's birth date: ______________

Physician: ______________ Physician phone number: ______________

Name of Parent(s) ______________ Phone number: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Signature of Parent: ______________ Relationship: ______________

Date: ______________