The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

PATIENT LABEL HERE
OR

Patient Name_____

Date of Birth_____

MRN_____

AUTHORIZATION TO TREAT A MINOR

Name of person authorized to present minor for care_____

Relationship of authorized person to present minor for care _____

Telephone where parents can be reached:

(H)_____ (W) _____

(Cell) _____

Address: _____

_____

_____

Minor's physician: _____ Phone: _____

Address: _____

Insurance Company: _____ Policy Number: _____

Last Tetanus or Diphtheria booster: _____

Allergies to drugs or foods: _____

_____

Any special medications or pertinent information: _____

_____

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent, parents, or legal guardian of _____ _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any duly licensed physician licensed under the provision of the laws of the State of Washington or any dentist licensed under the provisions of the law of the State of Washington. 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 which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

_____ _____
Signature of Parent, or legal Guardian Date