

Phone #s: () - () -

ANY OTHER INFORMATION THAT TEEN CENTER STAFF SHOULD BE AWARE OF:

PRIMARY INSURANCE COMPANY: _____

Phone #s: () - () -

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

SECONDARY INSURANCE COMPANY: _____

Phone #s: () - () -

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

STATEMENT OF CONSENT:

The undersigned do hereby consent to any examination, x-rays, medications, anesthetics, and surgical treatment of the above-mentioned minor that may become necessary based on the recommendations that may be made by the attending physicians. It is understood that this consent is given in advance of any accident or illness that may require diagnosis and treatment, but is given to encourage physicians to use their best judgment and proceed immediately with any necessary treatment. This authorization for diagnosis and treatment is valid only in the event that the undersigned parent or legal guardian cannot be reached in the case of an emergency, and shall remain in effect until revoked in writing.

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____