PARENT/GUARDIAN AUTHORIZATION FOR TREATMENT OF MINORS
(Volunteer under age 18)

SECTION I – TREATMENT AUTHORIZATION

I authorize the provision of medical and/or hospital care deemed necessary for:

First Name: _____ Middle Initial: ___Last Name: _____ Male__
Female__ Social Security #: _____ Date of Birth: ___/___/_____

In the event an illness or injury occurs during his/her volunteer service to the NSHE, I further authorize the following:

_____ I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment deemed necessary.

_____ I authorize all medical care units to release medical record information to the NSHE's workers compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the NSHE or insurance and hereby guarantee full payment to the physician or health care units.

SECTION II – PARENT/GUARDIAN INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____
Address: _____
Street City State Zip
Home #: _____ Work #: _____

Parent/Guardian Signature: _____ Date: __/__/____

SECTION III – PHYSICIAN/EMERGENCY CONTACT INFORMATION

Family Physician: _____ Phone: _____
Emergency Contact: _____ Phone: _____

SECTION IV – TO BE COMPLETED BY THE DEPARTMENT IN CASE OF INJURY OR ILLNESS

Date of Injury/Illness: _____ Body Part Injured: _____
Nature of the injury: _____
Name of emergency person contacted: _____
Date of Contact: ___/___/____ Phone #: _____
Completed by: _____ Extension: _____
Title: _____

Department Representative Signature: _____

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