AUTHORIZATION FOR TREATMENT OF A MINOR

NAME: ________________________________________ AGE: _______

MEDICATION/ALLERGIES: ______________________________________________________

1. IS PATIENT TAKING MEDICATION ON A REGULAR BASIS?
   
   ☐ Yes  ☐ No  If yes, what? ______________________________________________________

2. IS PATIENT UNDER A DOCTOR’S CARE AT THIS TIME FOR ANY MEDICAL PROBLEM?
   
   ☐ Yes  ☐ No  If yes, for what? __________________________________________________

   PHYSICIAN NAME: ___________________________ PHONE: ______________________

3. DOES PATIENT HAVE ANY CHRONIC MEDICAL PROBLEMS? (ASTHMA, DIABETES, EPILEPSY, ETC.)
   
   ☐ Yes  ☐ No  If yes, what? _____________________________________________________

4. HAS PATIENT HAD CLOSE RELATIVE PASS AWAY FROM A HEART ATTACK BEFORE AGE OF 40?
   
   ☐ Yes  ☐ No

5. DOES PATIENT HAVE A HISTORY OF A HEAD INJURY RESULTING IN A LOSS OF CONSCIOUSNESS?
   
   ☐ Yes  ☐ No  If yes, when? _____________________________________________________

6. DOES PATIENT HAVE A HISTORY OF MENTAL HEALTH PROBLEMS?
   
   ☐ Yes  ☐ No  If yes, what? _____________________________________________________

7. DATE OF LAST TETANUS SHOT: ___________________________ ______________________

8. OTHER COMMENTS: __________________________________________________________

                             I hereby grant permission for my child to undergo examination and receive medical care and/or treatment if necessary by
                             the Pat Walker Health Center professional staff.

NAME: _________________________ HOME PHONE: ___________ WORK PHONE: ___________

PLEASE PRINT

PARENT/GUARDIAN SIGNATURE: ___________________________________________ DATE: ____