

**JEFFERSON COUNTY PUBLIC SCHOOLS  
AUTHORIZATION TO TREAT A MINOR**

**TO: Any Hospital, Clinic or Physician**

I / We, the undersigned parent, parents, or legal guardian of \_\_\_\_\_  
authorize any hospital or clinic or licensed physician to treat my / our child with any X-ray  
examination, anesthetic, medical, or surgical treatment. 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 physician in the exercise of his best judgment  
may deem advisable. It is understood that reasonable effort shall be made by the respective school  
representative (i.e., coach, AD, or office personnel) to contact the undersigned prior to rendering  
the treatment to the patient, but that treatment will not be withheld if the undersigned cannot be  
reached.

\_\_\_\_\_  
Signature of Coach / Witness

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

List any restrictions to your authorization to treat: \_\_\_\_\_  
\_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Preferred Physician: \_\_\_\_\_

Consent valid for school year: \_\_\_\_\_

.....  
(For Office Use Only)

*Initial responsibility will be the respective school*

**ATTEMPT TO CONTACT PARENT**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Numbers Called

\_\_\_\_\_  
Signature of personnel who attempted to make contact

\*\*\* COPY OF THIS CONSENT TO \*\*\*  
ACCOMPANY STUDENT ATHLETE TO DOCTOR'S OFFICE