SaintFrancis Health System Warren Clinic

AUTHORIZATION FOR TREATMENT TO MINOR

987-011A / 02-05

MINOR'S NAME IN FULL

DATE OF BIRTH	MEDICAL RECORD NUMBER

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Warren Clinic to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until child may legally consent for him or herself.

SIGNATURE - PARENT OR LEGAL GUARDIAN	DATE

SIGNATURE - PARENT OR LEGAL GUARDIAN	DATE

WITNESS	DATE

I declare under penalty of perjury under the laws of the State of Oklahoma that the foregoing is true and correct.

SIGNATURE	DATE

County of _____)
) SS.
State of _____)

Subscribed and sworn to before me on this _____ day of _____ , 20 _____ .

NOTARY PUBLIC

NOTARY STAMP

_____
COMM. NO.

_____
COMM. EXPIRES

_____