MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of an emergency. This is extremely important, in that, medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

Minor's Full Name _____

Minor's Address _____

City, State, Zip Code _____

Minor's Age _____

The undersigned do hereby authorize the following representatives from Augustana University as agent/s for the Undersigned.

Representative's Name _____

Representative's Name _____

Representative's Name _____

This allows consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

*Parent or Guardian Name (please print)*_____

Parent or Guardian Signature _____

*Date*_____

Parent or Guardian Address _____

Parent or Guardian Phone _____