AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Authorization is given to the MBT representative to consent to medical treatment for my child, ______________________________________; and if admission to the hospital is recommended by our private physician or a consulting physician of his/her choice. We will be responsible for the charges for any medical treatment or hospitalization rendered by reason of this authorization.

CHILD'S BIRTH DATE ________________________________

NAME OF PRIVATE PHYSICIAN______________________________________ PHONE (_____)______________________

MEDICAL HISTORY (List any chronic or existing diseases or medical problems, *especially allergies*)

____

____

____

DATE OF LAST TETANUS SHOT ________________________

MEDICINES YOUR CHILD IS TAKING NOW (include dose and times per day) _______________________________________

____

NAME OF CHILD'S DENTIST____ PHONE (_____)______________________

NAME OF MEDICAL INSURANCE ____

MAILING ADDRESS FOR CLAIMS____

MEMBER'S NAME _______________________________________ MEMBER'S DATE OF BIRTH______________________

MEMBER'S SOCIAL SECURITY NUMBER____

GROUP BENEFIT CODE______________________________ IDENTIFICATION NUMBER_____________________________

ADDRESS AND TELEPHONE NUMBERS WHERE PARENT(S) MIGHT BE REACHED (if different from the front of this form)

ADDRESS:____

HOME PHONE: (_____)________________________________

MOTHER’S WORK PHONE: (_____)______________________ FATHER’S WORK PHONE: (_____)______________________

MOTHER’S CELL PHONE: (_____)_______________________ FATHER’S CELL PHONE: (_____)_______________________

MOTHER’S PAGER: (_____)____________________________ FATHER’S PAGER: (_____)_____________________________

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Signature of Parent or Legal Guardian

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