AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Authorization is given to the HBC 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_____

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_____ IDENITFICATION NUMBER_____

ADDRESS & TELEPHONE NUMBERS WHERE PARENT(S) MIGHT BE REACHED:

ADDRESS_____

HOME PHONE: (____)_____

MOTHER'S WORK PHONE (____)_____FATHER'S WORK PHONE(____)_____

MOTHER'S CELL PHONE (____)_____ FATHER'S CELL PHONE (____)_____

_____

Signature of Parent or Legal Guardian