CADUCEUS

OCCUPATIONAL MEDICINE
Done Right.

Authorization For Minors
(Under Age 18)
To be completed by Parent/Legal Guardian of Minor patient
If minor does not have a photo ID, Parent/Guardian must be present.

PATIENT/DONOR NAME: _____

AGE: _ _____ ☐ MALE ☐ FEMALE

SOCIAL SECURITY #: _____-_____-_____ DOB: ____-____-_____

- I grant permission to the treating physician and medical staff to perform such diagnostic procedure(s) (drug screens, physicals, injections, blood work) and/or medical treatment as deemed necessary.
- I authorize all medical records to be released to the company authorizing the procedure(s) and all insurance carriers necessary.
- I understand that all conditions found during the above procedures will be my responsibility to follow up with my child's primary care physician and are not the responsibility of CADUCEUS.
- The parent/guardian of the minor must present a government-issued photo ID prior to services being rendered.

PARENT/LEGAL GUARDIAN NAME (PRINT): _____

CHECK ONE: ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

ADDRESS SAME AS PATIENT? ☐ YES ☐ NO If NO, please enter address:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

SOCIAL SECURITY #: _____-_____-_____

I certify I am the parent or legal guardian of the above-listed minor. I have carefully read this agreement and agree to its terms.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____