



## Minor Authorization Form

If your child needs help when you're not around, you'll be glad you authorized **Immediate Care**.

CHAPEL HILL  
650 North Girls School Road  
Indianapolis, IN 46214  
(317) 271-5080  
10th St. & Girls School Rd.

GREENWOOD  
1001 North Madison Avenue  
Greenwood, IN 46142  
(317) 888-3508  
Fry Rd. and Madison Ave.

NORA  
860 East 86th Street  
Indianapolis, IN 46240  
(317) 580-3200  
86th St. and Guilford Ave.

WASHINGTON SQUARE  
992 North Mitthoeffer  
Indianapolis, IN 46229  
(317) 899-5546  
10th St. and Mitthoeffer Rd.

An affiliate of  **St. Francis**

Open 7am to 11pm, 365 days a year

Including nights and weekends

NO APPOINTMENT NEEDED

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_,  
born on \_\_\_\_\_ delegate to \_\_\_\_\_ (name of person/agency) the authority to consent for medical and/or surgical treatment of  
this minor by a licensed Indiana physician should his/her condition so require it in my absence. I impose no specific limitation or prohibitions regarding treatment other  
than those that follow (if none, so state): \_\_\_\_\_. This authorization is effective for the following time  
period (dates) from \_\_\_\_\_ to \_\_\_\_\_. I certify I have read this form and understand its contents. I hereby  
acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I acknowledge I am responsible for  
all reasonable charges in connection with care and treatment rendered during this period.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Child's Primary Care Physician & Phone (may be needed for follow-up care or referral)

\_\_\_\_\_  
Parent/Guardian's Name (please print)

\_\_\_\_\_  
Child's Allergies, if any, including medication

\_\_\_\_\_  
Parent/Guardian's Home, Cell, and Work Phone Numbers

\_\_\_\_\_  
Child's Chronic/Existing Diseases or Medical Problems (e.g. diabetes, epilepsy)

\_\_\_\_\_  
Parent/Guardian's Home Address

\_\_\_\_\_  
Medicines your Child is Taking Now

\_\_\_\_\_  
City, State, Zip of Parent/Guardian

\_\_\_\_\_  
Date of Child's Last Tetanus Booster

\_\_\_\_\_  
Emergency phone number (where we can reach you while you're away)

\_\_\_\_\_  
Medical Insurance Carrier (a copy of the insurance card would be helpful)

\_\_\_\_\_  
Other Contact Person

\_\_\_\_\_  
Member's Name & Employer

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Insurance Company Address

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Witness' Name (Print)

\_\_\_\_\_  
Insurance ID #, Benefit Code, Plan Information