potomac pathways

CONSENT TO EXAMINE AND TREAT

Student Name: Last First Middle

Address

City State Zip

Date of Birth Social Security Number

Parent Name to contact in case of emergency

Emergency notification phone number

Alternate phone number(s)

I hereby authorize medical personnel contacted by Potomac Pathways and under the general or special supervision of a physician licensed under the provisions of the Medical Practice Act, to provide or conduct, upon the advice of the supervising physician, such medical procedures, as they deem appropriate to diagnose or treat the above named child. This may include physical examination, X-ray examination, anesthetic, inoculation, immunization, vaccination, medical or surgical diagnoses or treatment, or hospital care, psychiatric evaluation, observation or treatment, psychological evaluation, testing or treatment. I further hereby authorize and consent to X-ray examination, anesthetic, dental or surgical diagnoses or treatment, or hospital care to be rendered to my child as needed, by a dentist licensed under the provisions of the Dental Practice Act. I agree to pay all fees and costs to anyone rendering emergency medical or dental care to my child.

Signature of Parent/Guardian or Client (if over 18) Date