Authorization to Treat

I, the parent or legal guardian of the person referred to herein, do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical treatment rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital or emergency care facility holding a current license to operate a hospital or emergency care facility from the State of Virginia Department of Public Health. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable for the participant. I understand that all effort shall be made to contact me prior to rendering treatment to the participant, but any of the above treatment will not be withheld if I can not be reached. This authorization is given pursuant to the provisions of the Virginia Civil Code. This consent shall remain in effect until the end of their participation in the Skills Development Center program. In case of an emergency, I understand that every effort will be made to contact me or the designated contact person listed on the registration form. I understand that staff will contact 911 in the event of an emergency.

Signature of Participant **Date** **Printed Name of Participant**

Signature of Legal Guardian **Date** **Printed Name of Legal Guardian**