AUTHORIZATION FOR TREATMENT OF A MINOR

National Institutes of Health (NIH)
Bethesda, Maryland 20892

I hereby authorize the Occupational Medical Service at the National Institutes of Health to give ___________________________________ (son, daughter, legal dependent) with his or her consent a pre placement medical evaluation, provide any routine tests which are generally recognized as safe (e.g. tuberculosis skin test, blood analysis), any work-related immunizations which may be indicated and offer out-patient treatment of minor injuries. I understand that if my child has a serious condition or requires long-term treatment or hospitalization, I shall be notified so that arrangements may be made to refer him or her to our private physician or clinic for further care.

Signature: ____ Date: ____________________
(Parent or Legal Guardian)

Printed Name: ______________________________
(Parent or Legal Guardian)

Address:____

Telephone: (H) ____________________________________ (W) ________________________

Minor's Name: _________________________________ Minor's SSN (Last 4 digits only):_____

Original must be returned to Occupational Medical Service, 10 Center Dr., Building 10, Room 6C306, Bethesda, MD 20892

Revised 1/22/15