YOU MUST FILL OUT AND BRING THIS FORM WITH YOU TO YWP

Authorization to Consent Treatment of Minors

Peconic Bay Medical Center
1300 Roanoke Avenue
Riverhead, NY 11901
Phone: (631) 548-6000

I/We, the undersigned, parent(s)/guardian(s) of the minor(s) listed below, do hereby authorize NYS Department of Environmental Conservation, Hunter Education Program staff, as our agent(s) to consent any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon at the *Peconic Bay Medical Center*, when such diagnosis or treatment is rendered at said hospital. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

Name of Minor	**Birth Date**	**Allergies**

This authorization shall remain effective from April 20th until April 21st unless sooner revoked in writing delivered to said agent(s).

Parent(s)/Guardian(s) Signature..... **Date:**.....

Witness Signature..... **Date:**.....

Parent(s) /Guardian(s) Information

Phone Numbers of Parent(s)/Guardian(s):
Home:..... Work:.....

Permanent Address:
.....
.....
.....

Temporary Address (if different than above):
.....
.....
.....