AUTHORIZATION AND CONSENT ON BEHALF OF A MINOR

Child's Name: (Last) ______________________ (First) ________________________
Home Address: ____
Date of Birth: _____________________ Social Security Number: _________________
Employer or Prospective Employer Name:_____________________________________

DRUG AND/OR ALCOHOL SCREENING, PHYSICAL EXAMINATION, AND INJURY TREATMENT AUTHORIZATION AND CONSENT TO RELEASE OF INFORMATION.

I, ____, Parent/Legal Guardian of the above-named child, authorize WORKNET Occupational Medicine, it's employees and agents, together with any hospital or laboratory designated by WORKNET, to perform appropriate tests required for injury treatment, drug or alcohol screenings, or physical examinations, and further authorize the release of the information, or screening results to WORKNET and the above-named Employer/Prospective Employer and its representative, including Employer's/Prospective Employer's third-party payer. I understand that every effort shall be made to maintain proper confidentiality of this information.

Parent/Legal Guardian Name (Printed): _______________________________________
Address: ____
Parent/Legal Guardian Signature: ____
Witness Signature:____
Date:____

July 2002