



North Shore-Long Island Jewish Health System

AUTHORIZATION FOR MEDICAL SERVICE OF MINORS AND THOSE UNDER CUSTODIAL CARE

I _____, the parent /guardian of
(Print name)

_____, _____, hereby authorize
Last name, First Name Date of Birth

North Shore Long Island Jewish Health System (NSLIJHS), through its medical staff, to perform the following, for pre-placement medical evaluation and clearance of individual named above:

- Urine Toxicology for drug testing *Parents/Guardians will be notified of positive results*
Note: if you have difficulty voiding on demand, please do not urinate for some time prior to your appointment.
- Tuberculosis Skin Testing (TST/PPD)
- Vaccinations (if necessary)
- Chest X-Ray (if necessary)
- Physical Exam (if medical clearance from private physician is not available)
- Other testing (as deemed necessary)

Parent/Guardian Signature Date: _____

In addition, I hereby authorize the NSLIJHS, through designated members of its medical/nursing staff, to examine and (as necessary) treat the individual named above, who is under the age of 18, and/or under my guardianship in the event of any accident, injury or illness which may occur in the course of serving as an employee/volunteer at NSLIJHS.

I understand and acknowledge that, whenever feasible, NSLIJHS will try to contact me and obtain my consent prior to providing such medical services. However, in an emergency, care may be provided without such consent.

Parent/Guardian Signature Date: _____

Address: _____

Home Telephone #: _____ Work /cell phone #: _____

Physician Name: _____ Telephone # _____