

2009-2010 SCHOOL YEAR

AUTHORIZATION OF CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, (We) _____ parents of _____
(Parent/Guardian) (Parent/Guardian) (child)

(address) (city) (county)

do hereby state that I am (we are) the natural parent(s) (legal guardian(s) having legal custody of

_____, a minor, age _____, born _____, who resides with me (us) at
(child)

_____. I authorize _____
(address) (relative, friend)

an adult, who resides at _____
(address) (city) (state) (county)

or _____, an adult, who resides at _____
(relative, friend) (address)

_____, to consent to necessary services including any
(city) (state) (county)

x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state(s) of _____, when the need for such treatment is immediate, and when efforts to contact me(us) are unsuccessful, and agree to assume all financial responsibility for those services. This authorization is to be effective from August, 2009 to June, 2010.

Signature of Parent or Guardian

Dated _____, 2009

Child's Doctor _____ Parent's Doctor _____

Child's allergies, if any _____

Medicine child is taking _____

Health Insurance Company _____