AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF MINOR CHILD AT ANY MEDICAL FACILITY

Date: ____________________________

Authorization is hereby given to ____
(Name of Designated Person)

to consent to emergency treatment of my child ____
(Name of Child)

and to proceed with any treatment that may be necessary in that we the parents are not available at the time of injury or illness.

Authorization is also given for admission to the hospital, if at the time of injury or illness, in our absence, admission to the hospital is advised by our private physician or a consulting physician of his choice.

Child's Date of Birth: ____

Child's Allergies and/or Chronic illness: ____

Private Physician Information:

Name: ____

Address: ____

Phone: ____

Child Insurance Information:

Name of Insurance: ____

Insurance ID Numbers: ____

Guarantor Name: ____

____ ____________
Signature of Responsible Party during Parents Absence as named above Date

____ ____________
Signature of Child's Mother Date

____ ____________
Signature of Child's Father Date

NOTARY:
Subscribed and Sworn to before me this ___________ day __________________ 20 _________ .

Witness my hand and official seal. My commission Expires: ______________________________

Notary Public: ____