AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR CHILD

Child's Full Name: _____

Age: _____ Birthdate: _____ Gender: Male or Female (circle one)

Social Security Number: _____ Phone: _____

Allergies: _____

Tetanus: (date of last immunization) _____

Medications currently taking (note name, dosage, and times taken): _____

_____

Family Doctor (include phone number): _____

_____

Recent illness / exposure to communicable disease (ie, measles, chickon pox, etc.): _____

_____

Mother's Name: _____ Phone 1: _____
(Please include area code)

Phone 2:_____Phone 3:_____
(Please include area code) (Please include area code)

Address: _____City, ST, Zip_____

Father's Name: _____ Phone 1: _____
(Please include area code)

Phone 2:_____Phone 3:_____
(Please include area code) (Please include area code)

Address: _____City, ST, Zip_____

Insurance Company Name and Contract Number: _____

_____

Name of responsible party in absence of parents or legal guardian: _____

Phone 1:_____Phone 2:_____
(Please include area code) (Please include area code)

Address: _____City, ST, Zip_____

(Over)

I (we) the parent(s) of the child named on reverse, hereby authorize _____, to consent and agree to any emergency medical, surgical or dental care or treatment by any hospital, emergency care provider, physician or dentist that he/she deems necessary and fit.

Parent(s) Signature(s): _____

_____

Dated this, the _____ day of _____, _____

NOTARY PUBLIC:

State of _____

County of _____

I, the undersigned, a notary public in and for the said county and state, hereby certify that _____, whose name is signed to the foregoing instrument and who is known to me, acknowledged before me on this day that, being informed of the contents of the instrument, _____ executed the same voluntarily on the day the same bears date.

Given under my hand and seal this _____ day of _____, _____

_____
Notary Public

NOTARIAL SEAL

_____
My Commission Expires This Date