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: _____