Authorization of Medical Treatment

AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and authorized person can be reached.

Father's name ___________________________________ Phone ________________

Mother's name __________________________________ Phone _________________

Another authorized person ____

Address ____Phone________________

Another authorized person ____

Address____Phone___________________

I, ____________________________________ hereby give permission to _________________

To obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is ____ and date of birth is ______________________ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further consent to transportation of the above named child to the nearest or most appropriated medical facility.

The medical insurance company that covers the above named child is:

Company Name ____

Company Address ____

Name of Policy Holder ______________________________ Policy Number _________

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

Signature of Parent/Guardian ____________________________ Date ___________________

Signature of Witness __________________________________ Date ___________________