Authorization of Medical Treatment

AUTHORIZED ADULTS

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

Father's name: _____ Phone: _____

Mother's name: _____ Phone: _____

Another authorized person: _____

Address: _____

I, _____ hereby give permission to _____ to obtain medical or surgical care form a health care facility, physicians, or dentist 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/dentist may be taken. I further consent to transportation of the above named child to the nearest or most appropriate 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 to charges not covered by any insurance payments.

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____