# 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 from 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: _____