

Authorization to Treat Form

I, _____ (Parent/Guardian Name)

hereby give permission for any and all medical attention to be administered to my child

_____ (Child's Name)

in the event of accident, injury, sickness, etc. Under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Address:

Insurance Company: _____

ID. And Policy Numbers: _____

In case I cannot be reached, any of the following persons is designated to act on my behalf:

- _____
- _____
- _____
- _____

Physician: _____

Address: _____

Phone: _____

Known Allergies: _____

Signature (parent/Guardian) _____ Date _____

Subscribed and sworn before me _____ day of _____, 20__

Notary Public