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