CHILD'S NAME:________________________DATE OF BIRTH________________

ADDRESS:____

FATHER'S NAME____________________EMPLOYED AT:___________________

HOME PHONE:_____________________BUSINESS PHONE:________________

MOTHER'S NAME:__________________EMPLOYED AT:___________________

HOME PHONE:_____________________BUSINESS PHONE:________________

CHILD'S DOCTOR___________________FAMILY DOCTOR:_________________

CHILD IS ALLERGIC

TO:____

MEDICAL INFORMATION (including last Tetanus shot, major illness):_______________

____

INSURANCE COMPANY & POLICY NUMBERS:___________________________

____

RESPONSIBLE PARTY____

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child____(name) in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physicians and nursing personnel within the hospital as well as any physician where treatment is rendered in the physicians office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child.

____ _______________

Signature of Parent or Legal Guardian Date

____ _______________

Witness Date