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Authorization for Medical Treatment of a Minor

I _____ do hereby state that I am the parent or legal

guardian of _____, a minor, (DOB) _____ who

resides with me at: _____

Home Phone: _____Cell Phone: _____

Parent's Employer: _____ Parent's work phone _____

I authorize the following individuals, all adults, to consent to any necessary medical examination, medical diagnosis, surgery, treatment and hospital care to be rendered to the above named minor. This will be done under the general or special supervision of any physician or surgeon licensed to practice medicine.

1. Name of Adult: _____ Relationship to minor_____

   Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name of Adult: _____ Relationship to minor _____

   Home Phone: _____Cell Phone: _____ Work Phone: _____

3. Name of Adult: _____ Relationship to minor _____

   Home Phone: _____ Cell Phone: _____ Work Phone: _____

Child's Primary Physician: _____

Physician's Phone: _____

_____ _____

Parent/Guardian Signature Date

Fax number: 941.761.9223