AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I/we (Name of parent/guardian): _____ and (Name of parent/guardian): _____ of (city): _____ _____, (county): _____ (state): _____ do hereby state that I am (we are) the natural parents(s)/legal guardian(s) having legal custody of the following minor children:

NAME	AGE	BIRTHDATE	ALLERGIES

Who resides with me (us) at: _____

(telephone): _____ (cell) _____.

I/we authorize: _____, an adult, who resides at (city): _____, (county): _____ (state): _____ , to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatments, and hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of: _____, when the need for such treatment is imminent and when efforts to contact me (us) are unsuccessful.

Dated this _____ day of _____, 20_____.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____