

PARENTAL AUTHORIZATION

Consent to Medical Treatment for Child

I, _____, of _____,

Address _____

City _____ St _____ Zip _____

am the parent or legal guardian having legal custody of the child(ren) listed below.
While being absent from my child(ren), from

mo. _____ day _____ year _____ until mo. _____ day _____ year _____

I have entrusted his/her/their care to:

Name _____

Address _____

City _____ St _____ Zip _____

I authorize the adult(s) listed above to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the child(ren) under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the Commonwealth of Kentucky and/or state of Indiana.

CHILD'S NAME	DATE OF BIRTH	ALLERGIES	CURRENT MEDICATIONS
1. _____ Pertinent Medical History _____	_____	_____	_____
2. _____ Pertinent Medical History _____	_____	_____	_____
3. _____ Pertinent Medical History _____	_____	_____	_____
4. _____ Pertinent Medical History _____	_____	_____	_____

Child's Doctor Name: _____ Phone #: _____

Medical Insurance Information: Policy Holder _____

Insurance Co. _____

Policy Number _____ Group # _____

This authorization shall only be effective during my absence on the dates set forth above. I agree to be financially responsible for all costs of medical treatment rendered to my child(ren).

Parent Signature: _____ Date _____

Witness Signature: _____ Date _____