# Authorization of Medical Treatment

**AUTHORIZED ADULTS**

In the event of an emergency, please indicate your name and phone number where you and an authorized person can be reached:

Father's name: _____ Phone: _____

Mother's name: _____ Phone: _____

Other authorized person: _____ Phone: _____

Address: _____

I, _____ hereby give permission to _____

To obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the phsicians/dentists may be taken. I further consent to transportation of the above named child to the nearest or most appropriate medical facility.

The medical insurance company that covers the above named child is:

Company Name: _____

Company Address: _____

Name of Policy Holder: _____ Policy Number: _____

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date