

PARENTAL AUTHORIZATION
Consent to Medical Treatment for Child

I, _____, of _____ (address),
am the parent having legal custody of the child(ren) listed below. While being absent from my child(ren),
from ____/____/____ until ____/____/____ I have entrusted his/her/their care to:
Mo. Day Year Mo. Day Year

Name _____

Address _____

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	DATE OF LAST TETANUS SHOT	CURRENT MEDICATIONS
--------------	---------------	------------------------------	---------------------

1. _____

Allergies _____

Pertinent Medical History _____

2. _____

Allergies _____

Pertinent Medical History _____

3. _____

Allergies _____

Pertinent Medical History _____

4. _____

Allergies _____

Pertinent Medical History _____

Child's Doctor: Name _____ Phone _____

Medical Insurance Information: Policy Holder _____

Insurance Co. _____

Policy Number _____ Group Number _____

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).

Signed: _____ Date: _____

Witness: _____ Date: _____