CONSENT FOR TREATMENT

In the case of my (our) absence or unavailability, you are hereby authorized to perform or arrange for whatever treatment you may consider necessary for my (our) child(ren): *(List full names and ages of each child)*

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____

____

In addition, please notify: ____
(Name, address, phone)

____

of the advisability of treatment, if any is to be performed under this authorization. Should specialist advice or treatment be required, our preferences are as follows:

Hospital ___________________________ Family Physician ______________________________

Surgeon ___________________________ Ophthalmologist ______________________________

Pediatrician ________________________ Dentist ____________________________________

Other ____

ALLERGIES of each minor child:

____

____

____

Date of Signature _____________________ Home Phone _____________________________

Signature ____________________________ Work Phone _____________________________

Address ____

Insurance Company __________________________________ Number ______________________

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