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AUTHORIZATION TO TREAT A MINOR

I, _____, parent or legal guardian of _____
Parent/Legal Guardian Name *Minor Child Name*

hereby authorize the following person(s) to accompany my child and request medical evaluation/treatment/hospitalization for the above named minor child, in my absence. Further, I authorize the following person(s) to sign all papers on my behalf for the furnishing of such services:

1. _____
Name *Address* *TelephoneE* *Relationship*
2. _____
Name *Address* *TelephoneE* *Relationship*
3. _____
Name *Address* *TelephoneE* *Relationship*
4. _____
Name *Address* *TelephoneE* *Relationship*

This authorization shall remain in effect until: _____

Parent/Legal Guardian Signature *Date*