AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF PARTICIPANT________________________________BIRTH DATE___________

IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

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I/WE, BEING THE PARENT (S) OR LEGAL GUARDIAN (S) OF THE ABOVE NAMED MINOR, DO HEREBY APPOINT:

NAME	ADDRESS	PHONE
Tom LaFave	Erieville, N.Y.	427-2995

TO ACT IN MY/BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE MENTIONED MINOR (S) DURING THE PERIOD OF MY/OUR ABSENCE FROM:

MONTH/DAY/YEAR through MONTH/DAY/YEAR

___________________ through ___________________

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.

1. ____

   Parent Guardian Signature	Address	Phone

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   Witness Signature	Address	Phone

2. ____

   Parent Guardian Signature	Address	Phone

   ____

   Witness Signature	Address	Phone

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S)

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INSURANCE COMPANY	I.D. OR CONTRACT NUMBER

FAMILY PHYSICIANS:

________________________	________________________

NAME AND NUMBER	NAME AND NUMBER