



AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF PARTICIPANT _____ BIRTH DATE _____

IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

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

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE</u>
Jen Fox	Cicero, N.Y.	699-6257

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

Witness Signature Address Phone

2. _____
Parent Guardian Signature Address Phone

Witness Signature Address Phone

HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S)

INSURANCE COMPANY I.D. OR CONTRACT NUMBER

FAMILY PHYSICIANS:

NAME AND NUMBER

NAME AND NUMBER