MEDICAL CONSENT FOR TREATMENT OF A MINOR

In the event my child needs medical treatment and the treating facility cannot reach me, I authorize the following adult(s) to give consent for medical treatment, including emergency surgery:

Name of authorized adult: ________Justin Mourn________________________

Name of authorized adult: __________________ ________________________

INFORMATION ABOUT MY CHILD:

Name:____________________________________ Date of Birth:_________________

Address:____

Chronic illnesses or allergies:____

____

Current Medications:____

Date of last tetanus shot:______________________

Child's personal physician:__________________________ Phone:________________

Health insurance company:____

Health insurance group #:____

Person who will be responsible for payment:__________________ Phone:__________

INFORMATION ABOUT ME:
I am the child's: [ ] parent [ ] stepparent [ ] legal guardian [ ] other _____________

Home address:____

Home Phone:____________ Cell Phone:____________ Work Phone:_____________

In case of emergency, the following person would know how to reach me:

Name:______________________ Home Phone:__________ Other Phone:__________

PERIOD OF AUTHORIZATION:
I want this consent to be in effect from (date) Jan. 1, 2010 to (date) Dec. 31, 2010 .

I understand that the persons authorized by me must be at least 18 years old and must be prepared to verify their identification if my child needs medical treatment. I also understand the authorized persons must present this form for treatment.

My signature:______________________________ Date:____________

Signature of witness:________________________ Date:____________
(witness must be someone other than a family member)