AUTHORIZATION FOR APPOINTING DELEGATE FOR TREATMENT OF MINOR

CHILD'S NAME: DATE OF BIRTH: ACCOUNT #:

______________________________ _______________ ________________

I/We being the parent(s) or legal guardian of the above-named minor do hereby appoint:

______________________________________ __________________________
Name Phone number

____
Relationship to Child

To act on my/our behalf in authorizing medical, dental or surgical care and hospitalization in my/our absence for the above-named minor.

PARENT/GUARDIAN SIGNATURE: ____

PARENT/GUARDIAN (PRINTED): ____

Street Address: ____

City: __________________________________State: ____________ZipCode: __________

Home Phone: ______________________Work Phone: _____________________________

Date: _____________________ Expiration Date: * ____________________

*Unless otherwise stated, this authorization will remain in effect until revoked by me in writing.

Witness Signature: ____